State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 15
(1/1/2019 – 12/31/2019)

Quarterly Report for the period
July 1, 2019 – September 30, 2019

Submitted Via PMDA Portal on November 15, 2019

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I. Background and Introduction

The Global Commitment to Health is a Demonstration Waiver authorized pursuant to Section 1115(a) by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

The initial Global Commitment to Health (GC) and Choices for Care (CFC) demonstrations were approved in September 2005, effective October 1, 2005. The GC demonstration was extended for three years, effective January 1, 2011, and again for three years effective October 2, 2013. The GC demonstration was again renewed for five years effective January 1, 2017. The CFC demonstration was extended for 5 years effective October 1, 2010. The following amendments have been made to the GC demonstration:

- 2007: a component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.

- 2009: the state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

- 2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

- 2012: CMS provided authority for the State to eliminate the $75 inpatient admission copay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.

- 2013: CMS approved the extension of the GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the State received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

- 2016: On October 24, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017 through December 31, 2021.

- 2018: As of July 1, 2018, the Global Commitment to Health demonstration was amended to include authority for Vermont to receive federal Medicaid funding for Substance Use Disorder treatment services provided to Medicaid enrollees in Institutions for Mental Disease (IMDs).

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-Governmental Agreement (IGA) with the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR §438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the third quarterly report for waiver year 15, covering the period from July 1, 2019 through September 30, 2019 (QE0919).***

II. Outreach/Innovative Activities

i. Provider and Member Relations

Key updates from QE0919:
- Medicaid Member Outreach and Education
- Non-Emergency Transportation and Medication-Assisted Treatment
- MMIS Provider Management Module (PMM)

The Provider and Member Relations (PMR) Unit ensures members have access to appropriate health care for their medical, dental, and mental health needs. The PMR Unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and is responsible for implementation of the enrollment, screening, and revalidation of providers in accordance with Title 42 Code of Federal Regulations (CFR) §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

The PMR Unit also collaborates with GMC's Customer Support Center to better address and assess GMC member issues and needs.

<u>The Provider Management Module (PMM)</u>

The Provider Management Module (PMM) went live on May 1, 2019. This has been a year-long endeavor starting with the signing of Act 166 by Governor Scott on May 1, 2018 mandating enrollment of Medicaid providers in 60 days or less.

The Provider Management Module to enroll and manage provider information online has been live since May 1, 2019 with over 2,000 providers enrolling in an average of 18 days. Currently in the Execution Phase of the project, the project schedule, scope, and budget are green and PMR staff are finalizing project SOW deliverables. R3 Certification is currently set for November 21, 2019 with

overall completion at 89% and planning for the first PMM Product Release (R14/15) post go-live is ongoing (for enhancements to the system and set to be deployed 1/16/2020.

Medicaid Member Outreach and Engagement

The PMR Unit is increasing its efforts to better serve the Vermont Medicaid member community through improved methods of outreach and information sharing. The goal of this initiative is to deliver timely news and information on platforms that better suit members' access and needs while promoting a proactive approach to member engagement. PMR is transitioning away from paper newsletter mailings and will begin to focus on engaging members through various electronic platforms, beginning with the Green Mountain Care website. PMR will also begin to work across the Department and the Agency in order to ensure that all information is timely, relevant, and accurate, work is not duplicated, and all resources are leveraged and utilized to their maximum potential.

Non-Emergency Transportation and Medication-Assisted Treatment

Provider Member Relations is currently collaborating with BAART Programs to streamline transportation needs for Medicaid members. PMR staff members have met with them twice to talk about efficiencies and needs of members; PMR staff have also developed a streamlined intake form if members need transportation to treatment that describes how the Non-Emergency Transportation program will assist. This is an exciting collaboration and PMR is looking to replicate this process. BAART Programs Berlin provides outpatient, opioid use disorder treatment with medication, counseling and supportive recovery services. Also known as Central Vermont Addiction Medicine, BAART Berlin is a member of the Care Alliance for Opioid Addiction in Vermont. The Care Alliance is a statewide partnership of clinicians and treatment centers providing Medication-Assisted Therapy (MAT) to individuals suffering from an addiction to opioids.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0919:

- The Customer Support Center received received just over 87,000 calls in QE0919. Call volume is up 3.5% in QE0919 as compared to QE0918.
- Vermont Health Connect is currently supported by 186 Assisters, down from 242 in QE0619.
- Increasing numbers of customers are using self-service functions, especially recurring payments. 61% was the average of customers who made recurring payments in QE0919. This is a 2% growth from the prior quarter.

Enrollment

As of QE0919, more than 192,604 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 111,709 in Medicaid for Children and Adults (MCA) and 80,895 in Qualified Health Plans (QHPs), with the latter divided between 25,529 enrolled with VHC, 7,156 direct-enrolled with

their insurance carrier as individuals, and 48,210 enrolled with their small business employer.

Member Experience

In preparing for this year's open enrollment, the State is leveraging the information received from the survey that was conducted on Vermont's health insurance marketplace members regarding their experience during last year's open enrollment. The information collected helped to drive the overall communication plan centered on education of the plans, options, and channels for help. This open enrollment, there are five key points the State is ensuring each Vermonter has clear, concise, and direct information on:

- State mandate requirement
- Increased financial help
- Plan comparison tool
- Direct enrollment for Vermonters with no financial assistance
- Ability to self-serve online or to call the call centers

Medicaid Renewals

Redeterminations for Medicaid for Children and Adults (MCA) continued on their normal cycle during QE0919. The passive renewal success rate for the quarter averaged 39%, an increase from the monthly average over the last quarter. The Zero Authorization logic that identities if members can be submitted to the Hub for verification had a defect which caused the decrease in the passive renewal success rate for July and August. The solution was implemented for August and the success rate increased to 49% that month. We expect that percentage to be maintained moving forward.

Pre-populated renewal applications were sent to the remainder of the population, requiring an active response. As of the last day of the quarter, DVHA-HAEEU had 32 open applications, one of which is older than 45 days.

1095 Tax Forms

The last corrections run for the 2018 1095B was on 8/19/19. Preparations are underway for the initial EOY 2019 1095B generation which will begin in December.

Customer Support Center

DVHA continues to contract with Maximus to staff and manage the VHC Customer Support Center. The Customer Support Center serves Vermonters enrolled in both public and private health insurance coverage by providing support with phone applications, payment, basic coverage questions, and change of circumstance requests.

The Customer Support Center received just over 87,000 calls in QE0919. Call volume is up 3.5% in QE0919 compared to QE0918.

Maximus answered 85% of calls within 24 seconds in July 2019, 80% in August 2019, and 84% in September 2019. Despite increased calls in QE0919, with increased staffing, Maximus exceeded the target of 75% of calls answered within 24 seconds for QE0919.

Maximus is continuing to hire staff as they prepare for Open Enrollment 2020. Presently, they have 93 staff and plan to be at 107 before Open Enrollment starts on 11/1/19. Maximus is also seeing signs of improved turnover rates of staff staying longer than six months.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. In QE0919, there was an increase in call volume; however, there was a decrease in the proportion of calls that were escalated to DVHA-HAEEU staff. In July, the transfer rate was 2%, in August the transfer rate was 2.6%, and in September the transfer rate went up to 7.6%. In QE0919, DVHA-HAEEU answered 95% of all transferred calls within five minutes compared to 96.7% in QE0619.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In the last two recent quarters (QE0619 andQE0919), more than 98% of the VHC requests were completed within the same ten-day time period.

System Performance

The system continued to operate as expected throughout most of QE0919, achieving 100% availability outside of scheduled maintenance. The average page load time for the quarter was 0.95 seconds -- well within the two-second target.

In-Person Assistance

Vermont Health Connect is currently supported by 186 Assisters (104 Certified Application Counselors, 1 Navigator, and 81 Brokers), down from 242 at the end of QE0619. There are currently 49 Certified Application Counselors in training representing an upward return in total number of Assisters. The fluctuation in numbers represents external organizational attrition coupled with strategic and intentional program recruitment efforts to focus on the areas of the State that have the highest Assister need and utilization. The program has also implemented significant improvements to training, communication, and process and data quality and consistency. With its renewed focus, in the next quarter the program is expected to continue to grow in number of Assisters, customers served, and areas covered. DVHA held its annual Assister conference on 10/24/19 to continue to provide support and connection for the State's in-person Assisters, The 2019 conference saw an increase in the number of attendees over the 2018 conference.

Outreach

Health insurance literacy was also an outreach focus throughout QE0919. DVHA-HAEEU engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of responding to Medicaid renewal notices and comparing options for Qualified Health Plans. Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, with more than 60,000 visits to the site's Help Center.

The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 13,000 sessions during the quarter, up 30% over the previous year.

Self-Service

During QE0919, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments. Automatic recurring payments ensure that members' premiums are paid on time, helping them to avoid going into a grace period – and ultimately losing coverage – due to late payments. Self-serve applications comprised nearly half (49%) of all applications in QE0919, up slightly from QE0918 (46%). More than 7,000 customers made recurring payments per month in QE0919. Overall, 36% of all payments made per month are recurring payments and 61% of all electronic payments in QE0919 were recurring payments.

ii. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE0919:

- Vermont implements 2% rate increase
- Conflict Free Case Management System Evaluation in Full Swing

Rate Increases

DAIL implemented a 2% increase for all Choices for Care home-based (High, Highest & Moderate Needs), Adult Family Care, Enhanced Residential Care and Traumatic Brain Injury (TBI) services effective July 1, 2019.

New Minimum Wage

July 1, 2019, DAIL implemented new minimum wage requirements found in the State's Collective Bargaining Agreement for Independent Direct Support Workers. The minimum wage went from $11.30 an hour to $11.55 an hour for all employees of self-managed hourly services, and from $172 per day to $176.48 per day for daily respite. Using the minimum wages as a starting point, employers are allowed to set their own wages for their employees within their state-approved individualized budget.

Choices for Care Regulations

DAIL incorporated stakeholder input on the new draft Choices for Care state regulations that were reported in the QE0619 report.The draft rules were pre-filed with the Interagency Committee on Administrative Rules in August 2019 and a public hearing scheduled for October 4, 2019. In alignment

with administrative rulemaking, AHS is seeking to update Attachment F of the Global Commitment waiver in accordance to STC 19(b) in order to modify the procedure for the Moderate Needs Group waitlist. The requested modification will allow for the waitlist to be managed according to an individual's clinical need via an applicant's priority score as opposed to managing via chronological order.

Conflict Free Case Management

In July 2019, DAIL worked with it's partners at DVHA to summarize stakeholder input on Phase I of Vermont's conflict free case management system evaluation of Choices for Care and the TBI program. (A summary of Phase I can be found here.) Phase II of the project, which started in September 2019, includes informing the public about the Phase I findings and then re-engaging stakeholders in a discussion about future options for Vermont to improve its HCBS case management delivery system.

Wait Lists

- There is currently no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 800 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list in the near future. However, the state is planning to revise the wait list procedures from chronological to priority-based in order to serve applicants with the greatest needs first.
- There is currently no wait list for the TBI program.

iii. Developmental Disabilities Services Division

Key updates from QE0919:
- New payment model in development
- HCBS rule implementation
- Waitlist

New Payment Model in Development

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). The program has grown significantly over the years from several hundred to several thousand participants. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS. The State has engaged stakeholders including recipients, families, advocacy organizations, and providers to participate in workgroups for the development and implementation of the new payment model.

A provider rate study has been completed and the state is in the process of collecting public comment on the recommended rates. Final recommended rates will be determined after the public input has been analyzed. The information from the rate study will be utilized in developing the new payment model. In addition to the provider rate study, the project is examining alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. An

RFP for a standardized assessment tool has been posted and the state is considering the one bid it received. Changes have been made to allow the MMIS to accept encounter claims to document service delivery. Providers are preparing their systems to be able to report the encounter data into the MMIS. Ongoing work will be required regarding changes to the payment methodology, including seeking any needed CMS approval.

HCBS Rule Implementation

DDSD continues to work on implementing the HCBS rules to ensure compliance with all requirements. Currently the state is working on addressing the issue of conflict of interest in case management. DVHA is working with departments who operate HCBS programs, including DDSD, to analyze HCBS case management across the state and is seeking stakeholder input on how to address any potential conflict of interest in each of the programs. In quarter 3, DAIL drafted 4 options for structuring case management in the DDSD program, as well as 7 additional strategies to mitigate conflicts of interest. These proposals were presented to the department and DDSD advisory committees, the DD Council, and a self-advocacy organization. In addition, 6 public forums were held to seek input on the proposals. All the information has now been collated and summarized. DAIL will now draft its solutions to address conflict of interest in case management and there will be one more round of stakeholder feedback on the proposed solution.

DDSD also continues to evaluate compliance with the HCBS settings rules. Provider sites have been evaluated and providers are being given plans of correction to ensure full compliance. No sites were identified for heightened scrutiny.

Wait List

DDSD collects information from service providers on individuals who request funding for HCBS and other services including Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI). The information is gathered by the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

1. HCBS Applicants: Individuals with DD who are clinically and financially eligible but who do not meet a funding priority for HCBS and have been denied services in whole or in part.
2. Individuals who are clinically and financially eligible for TCM, FMR, FFF or PSEI, but for whom there are insufficient funds.

As of 9/30/19, there were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. The full set of waiting list data is collated on an annual basis. This information will be provided in the 2019 Annual GC Report.

iv. Global Commitment Register

Key updates from QE0919:

- 25 policies were posted to the GCR in Q3 2019.
- Since the Global Commitment Register (GCR) launched in November 2015, 194 final GCR policies have been publicly posted.

The GCR is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. It is based on the Federal Register and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the DVHA website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 450 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity to provide comments on proposed GCR policies before the policies are made final. Comments received are posted in the GCR online. The GCR emails are also distributed to members of the Medicaid and Exchange Advisory Board.

A combined total of 25 policies were posted to the GCR this past quarter. This includes 11 proposed changes, 12 final changes, and 2 clarifications. Changes include updates to rates and/or rate methodologies, clinical coverage changes, administrative rulemaking notices, State Plan Amendment notices, and a proposed amendment to this 1115 waiver.

The GCR can be found here: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register.

v. Substance Use Disorder Program (SUD Demonstration Monitoring Report)

1. Title Page for Vermont's SUD Components of the Global Commitment to Health Demonstration

State	Vermont
Demonstration Name	Global Commitment to Health 1115 Demonstration
Approval Date	July 1, 2018
Approval Period	July 1, 2018 – December 31, 2021
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	*Enter summary of the SUD (or if broader demonstration, then SUD related) demonstration goals and objectives as summarized in the STCs and/or demonstration fact sheet.*

2. Executive Summary

During the third quarter of 2019 the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access Medication Assisted Treatment. The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) Substance Use Disorder Treatment Standards and corresponding compliance assessment tool have both been revised for a January 1, 2020 effective date.

ADAP continues to develop the value-based payment model for residential programs, to align with its All Payer Model Agreement with CMS, for implementation in 2020. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments are anticipated to be adjusted in the fourth quarter of 2019. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration.

Contract work for ADAP's Centralized Intake and Resource Center (CIRC) with Health Resources in Action (HRiA) continues. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to centrally manage appointments with ADAP's Preferred Provider Network. The service is anticipated to be available for public use during winter 2020.

The Substance Misuse Prevention Oversight and Advisory Council (SMPOAC) has been established within the Vermont Department of Health and encompasses all substances of misuse including alcohol; cannabis; controlled substances such as opioids, cocaine and methamphetamines; and tobacco products, tobacco substitutes and substances containing nicotine..

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018 at three sites. Currently, there are six sites up and running. 1497 individuals were seen in the EDs from July 1, 2018 – September 30, 2019. Two additional sites are opening in October 2019, and three in the beginning of 2020, one of which is currently serving one hospital.

The plan for the SUD Mid-Point Assessment was determined. An internal team has been established and is executing the plan. A survey of Preferred Providers was administered to collect their input regarding implementation of milestones #2 and #3.

3. Narrative Information on Implementation, by Reporting Topic

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?			There are no planned changes to the target population or clinical criteria.
Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation updates to report for this reporting topic.			

Milestone 1: Access to Critical Levels of Care for OUD and other SUDs

This reporting topic focuses on access to critical levels of care for OUD and other SUDs to assess the state's progress towards meeting Milestone 1.

<table>
<tr><th>Prompts</th><th>Demonstration Year (DY) and quarter first reported</th><th>Related metric (if any)</th><th>Summary</th></tr>
<tr><td colspan="4">2.2 Access to Critical Levels of Care for OUR and other SUDs (Milestone 1)</td></tr>
<tr><td colspan="4">2.2.1 Metric Trends</td></tr>
<tr><td>Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.</td><td></td><td></td><td></td></tr>
<tr><td>[Add rows as needed]</td><td></td><td></td><td></td></tr>
<tr><td colspan="4">☒ The state has no metrics trends to report for this reporting topic.</td></tr>
<tr><td colspan="4">2.2.2 Implementation Update</td></tr>
<tr><td colspan="4">Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to:
a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)?
SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs?

Summary: There are no planned changes to access to SUD treatment or the SUD benefit coverage.</td></tr>
<tr><td>Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.</td><td></td><td></td><td>There are no anticipated program changes.</td></tr>
<tr><td colspan="4">☒ The state has no implementation updates to report for this reporting topic.</td></tr>
</table>

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

This reporting topic focuses on use of evidence-based, SUD-specific patient placement criteria to assess the state's progress towards meeting Milestone 2.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
3.2.2 Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to:

a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?
b. Implementation of a utilization management approach to ensure:
    i. Beneficiaries have access to SUD services at the appropriate level of care?
    ii. Interventions are appropriate for the diagnosis and level of care?
    iii. Use of independent process for reviewing placement in residential treatment settings?

Summary: The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 24 substance use disorder treatment providers. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool have both been revised for a January 1, 2020 effective date.

Milestone 2 - Table 1

Action	Revised Completion Date	Responsible	Status
Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	August 15, 2018	Director of Quality Management and Compliance	Completed
Updated online recertification survey to reflect new revision of Substance Use Disorder Treatment Standards	October 31, 2018	Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level	December 31, 2018	Director of Clinical Services; Director of	Completed

3.5 Level of Care provider (Valley Vista Bradford)		Quality Management and Compliance	
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.3 Level of Care Provider (Recovery House)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed

Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is anticipated to be implemented in 2020. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments are anticipated to be adjusted in the fourth quarter of 2019. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration.

Milestone 2 – Table 2

Action	**Date**	**Responsible**
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont team to review	Completed	Payment Reform Team
Work with financial colleagues to finalize budget and rate decisions for the model	Completed	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	Completed	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system's changes required for the Medicaid billing system	Completed	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)
Work with the residential providers to provide technical assistance and education around the necessary billing changes	Completed	ADAP Clinical Team
Regional Managers will partner with the compliance and quality	Completed	ADAP Clinical Team and ADAP Quality Team

team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews			
Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

This reporting topic focuses on the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities to assess the state's progress towards meeting Milestone 3.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
4.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards? b. State review process for residential treatment providers' compliance with qualifications standards? c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site? **Summary**: The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 24 substance use disorder treatment providers. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool have both been revised for a January 1, 2020 effective date.			

Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

This reporting topic focuses on provider capacity at critical levels of care including for medication assisted treatment (MAT) for OUD to assess the state's progress towards meeting Milestone 4.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
5.2 Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
5.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care? **Summary**: Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is			

anticipated to be implemented in 2020. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments are anticipated to be adjusted in the fourth quarter of 2019. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration. Contract work for ADAP's Centralized Intake and Resource Center (CIRC) with Health Resources in Action (HRiA) continues. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to centrally manage appointments with ADAP's Preferred Provider Network. The service is anticipated to be available for public use during winter 2020.			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

This reporting topic focuses on the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD to assess the state's progress towards meeting Milestone 5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
6.2.2 Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD? b. Expansion of coverage for and access to naloxone? **Summary**: There are no planned changes to the prescribing guidelines and other interventions.			
Are there any other anticipated program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Milestone 6: Improved Care Coordination and Transitions between Levels of Care

This reporting topic focuses on care coordination and transitions between levels of care to assess the state's progress towards meeting Milestone 6.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
7.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports?			

Summary: Vermont launched the Recovery Coaches in the Emergency Department Program at six sites with two additional sites opening in October 2019, and three opening in the beginning of 2020. A total of 1497 individuals have been seen by recovery coaches.			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

SUD Health Information Technology (Health IT)

This reporting topic focuses on SUD health IT to assess the state's progress on the health IT portion of the implementation plan.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
8.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to: a. How health IT is being used to slow down the rate of growth of individuals identified with SUD? b. How health IT is being used to treat effectively individuals identified with SUD? c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD? d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels? e. Other aspects of the state's health IT implementation milestones? f. The timeline for achieving health IT implementation milestones? g. Planned activities to increase use and functionality of the state's prescription drug monitoring program?			

Summary:

- Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss has provided a change order to connect to RxCheck.
- Funding through the Center for Disease Control and Prevention, and the Bureau for Justice Administration requires the connection to RxCheck. The requirements to update and revise the MOU for the connection to RxCheck is in process. Vermont will be formalizing the relationship with IJIS by the end of the year.
- The current contract for the VPMS will be put out to bid later this year. The request for proposal (RFP) will include high priorities such as improved access and support for providers, integration and data management, and increased reporting functionality.
- VPMS, Dr. First and Appriss are testing and verifying Appriss's Gateway integration tool to enable direct population of VPMS data into Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems. Preliminary user acceptance testing has been completed and feedback submitted with a second round of user acceptance testing to be completed by the end of the year.
- VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.
- VPMS staff participated in interviews for the development of statewide data integration opportunities. These interviews were with the contractor tasked with developing the health IT infrastructure plans for the HIE Steering Committee and will be compiled with other data systems needs and requirements for integration.
- VDH promoted the availability of technical assistance at the prescriber level. Promotion was integrated into the implementation of prescriber insight reports; the impact of implementation of the insight reports is being evaluated. Insight reports include metrics for providers about the prescriptions dispensed that they prescribed and comparisons with other providers within their specialty. Vermont continues to offer prescriber reports on a quarterly basis. New enhancements to the report include metrics on stimulants and sedatives in addition to opioids. The scope of the providers receiving reports have been expanded and will now include those who have prescribed controlled substances other than opioids as well.
- VDH is conducting an impact evaluation of the 7/1/17 pain prescribing rule change; evaluation plan in place 12/2018. The goals are: assess the impact of the new prescribing rules on prescribing patterns, determine if new prescribing rules affect awareness/usage of VPMS and evaluate impact of stricter prescribing rules on future prescription opioid misuse. VDH continues to monitor trends to look for sustained change over time.
- The Centralized Intake and Resource Center (CIRC) will encompass a call center, public-facing informational website, and a web-based appointment board that will be leveraged to support waitlist management and interim services provision. Contracted work with the vendor, Health Resources in Action, has continued and this service is anticipated to be available for public use during winter 2020.

Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such			

metrics)? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			
Are there any other anticipated program changes that may impact the other SUD-related metrics? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the SUD component is part of a comprehensive			Updates on Budget Neutrality can be found in Section V. *Financial/Budget Neutrality Development/Issues* of this report.

demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
10.2.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			

SUD-Related Demonstration Operations and Policy

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's			

approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes or does the state expect to make any changes to: a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)? b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)? c. Partners involved in service delivery?			
Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			

What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar to or different from the SUD demonstration?			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			

SUD Demonstration Evaluation Update

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
12.1 SUD Demonstration Evaluation Update			
12.1.1 Narrative Information			
Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			Updates on the SUD evaluation work, deliverables, and timeline can be found in Sections VIII. *Quality Improvement* and IX. *Demonstration Evaluation* of this report.
Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
12.1.2 Implementation Update			

Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			

Other Demonstration Reporting

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
Have there been any changes in the state's implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			
Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to: a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports?			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. *Compliance* of this report.

Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
[Add rows as needed]			
☒ The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
[Add rows as needed]			
☒ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			

Notable State Achievements and/or Innovations

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related)			

demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
[Add rows as needed]			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0919:

- Strategic planning continues with DVHA Payment Reform Team and ACO for continued alignment of service delivery to Vermont; including training and mentoring on the Complex Care Model.
- Geographic Attribution Methodology pilot continues in one HSA; three VCCI staff with access to Vermont ACO Care Navigator as communication platform.
- CMS certification of the AHS MMIS Enterprise Care Management system;
- Admissions | Discharge | Transfer messaging from VHIE functional in care management system.
- VITL Informed Consent – VCCI actively signing members on in anticipation of change to opt in as default for consent.
- VITL Single Sign On (SSO) was deployed to the Care Management system.
- VCCI partnership with Vermont Department of Corrections on coordination of treatment upon member's release, to include population receiving (Hepatitis C+) HCV treatment.

The VCCI is a statewide Medicaid case management service for Medicaid beneficiaries. VCCI is comprised of licensed, field-based case managers and two non-licensed professional staff who operate in a decentralized VCCI model statewide, providing case management resources at the community level. Facilitation of access to clinically appropriate health care information and services; coordination of the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and education and empowering beneficiaries to eventually self-manage their chronic conditions are longstanding goals. Historically, VCCI has provided intensive, short term case management services to those who were predicted to be high cost/high risk. This was premised on

reports highlighting that the top 5% of Medicaid beneficiaries accounted for ~39% of Medicaid expenditures.

Population Enhancement

The emergence of the Accountable Care Organization (ACO) and a subsequent increase in the number of attributed lives to the Vermont Next Generation Medicaid ACO prompted the review of who VCCI would deliver case management services to and how best to deliver these services, as ACO attributed beneficiaries are currently not eligible to receive VCCI services. At the end CY2018, VCCI had implemented state-wide the enhancements to population served, and to the model of service delivery. The VCCI program shifted from a model of serving only high-risk beneficiaries, to include at -risk population, including the dually insured and adult members new to the health plan. The at-risk population may include beneficiaries identified by their healthcare and social service community providers, as in need and potentially able to benefit from VCCI case management services and the complex care model delivery - due to healthcare needs as well as challenges with social determinants of health such as housing, food security, and transportation issues. Statewide VCCI case managers continue to meet face to face with members where members are at – this could be in their homes, at provider offices, at shelters, in 'park and ride' lots where members are living out of their cars. Meeting location can change from visit to visit; and this may be compounded by inability to reach a member by phone. Despite the transient housing and financial status of the population, VCCI staff continue to demonstrate >80% rate at face to face meetings with members at least once/monthly.

Outreach to beneficiaries new to Medicaid continued with initial screening of members and their access to primary care, current health conditions, risky behaviors, and social determinants of health. A question of access to dental care was successfully added to the NTM screening tool. The goals remain to 1) orient the beneficiary to the system of care, including navigation of services for health-related needs such as housing/food security and facilitating connections to local domestic violence resources, and 2) onboard beneficiaries ahead of their anticipated ACO attribution to facilitate access to primary care and connect to community resources, including self-management programs. Beneficiaries' responses to screening questions coupled with the clinical judgment of VCCI case managers allows stratification into 1 of 4 risk levels – mirroring the ACO's framework. This past quarter, VCCI continued to work with VDH partners on the development of a screening tool for pediatric beneficiaries new to the Medicaid health plan. Themes in the screening remain focused on access to care, risk factors, and the presence of barriers with health-rated issues such as housing and food. It is anticipated that toward the end of CY 2019, the VCCI will pilot pediatric outreach, test the screening tool, and assess access to community services.

Alignment with Healthcare Reform | Geographic Attribution Pilot

A pilot effort continues in one health service area to assess nontraditionally attributed-ACO members for collaborative and strategic member outreach, ensuring connectedness to local system of care and implementing the Complex Care Model as needed. The Pilot team includes VCCI, Payment Reform, Blueprint, ACO, health service area leaders, and community team members. The population cohort is analyzed and broken down into different buckets, including those without any claims that demonstrate connectedness to community. It is this cohort, that the VCCI outreaches utilizing the current NTM screening tool. This past quarter, VCCI continued to outreach the cohort of Medicaid members without any claims with the goal of screening completion and connection to local including primary care provider establishment and dental care. Through the work in this pilot, the local FQHC organization

reviewed its workflow for accepting new patients and struck the requirement for receipt of former health records prior to scheduling a new patient appointment. Hospital owned practices are also following suit and striking the requirement as well. This increases access to primary care.

Collaborative work also included the development of an Implementation Guide on Geographic Attribution which is anticipated to be shared with two other communities for review. Two important areas identified for communities who may onboard with geographic attribution, to assess for in terms of preparedness are 1) to inventory with the local primary care practices and organizations their current processes for accepting new patients, wait lists, and discussion on any proposed changes to workflow that may ease burden of community workers trying to facilitate primary care, and 2) to assess community knowledge of what the complex model is and the readiness of the community to deliver the complex care model to include patient engagement tools and shared care planning.

This pilot was built upon the current foundation of the strong local partnerships and communication that exist in this service area as well as community team readiness.

Alignment with healthcare reform | Complex Care Model

In continued efforts to align with the healthcare reform and the ACO, the VCCI has been meeting with DVHA leadership and colleagues to include Payment Reform, the Blueprint, and the ACO. Initial work has been focused on assessing opportunities for statewide alignment in service delivery of the Complex Care Model as it has been recognized that there is system wide need for this curriculum to be updated and the need for development of a statewide training plan, with noted gap since 2017.

Leaders from each organization have a deliverable to review current materials with recommendations to add, delete, or change ahead of the next scheduled meeting. Materials include a wide array of review of patient engagement tools such as eco mapping, Camden cards with delivery model components of member identification of long term lead care coordinator, identification of care teams, development of shared care plan, pulling together care teams – with the beneficiary at center of this work. Historically, health care providers, case managers, care coordinators have been trained in this model. However, it is expected that other community partners within the social service arena and those workers that provide health related services to include state departments of Department of Children and Families (DCF) and Department of Corrections (DOC) will be invited to receive training, as they may be pivotal members of the care team. Currently, VCCI has one Trained Trainer in the Complex Care Model, who has partnered with other Trained Trainers to fill this gap, and who has to date, supported training of >80 individual workers.

Enhancing Partnership and Footprint within the Agency of Human Services

This quarter, the VCCI continued to work with the Agency of Human Services Field Directors on practical ways to address some of the barriers that members encounter when attempting to access General or Emergency Assistance (GA | EA) benefits. When members are inpatient in a hospital, it is hard for them to attend the face to face interview required to maintain a benefit, that may help support their housing and/or help pay the copays necessary on required prescriptions. The VCCI and AHS GA teams were able to brainstorm on a realistic solution and have agreed to eliminate the requirement of face to face interviews, for certain cohorts, and only after following current rules in place and have begun to mutually implement the plan this past quarter.

Unaffordable and unsafe housing continues to be an ever-present circumstance for our beneficiaries and families. Both financial and structural resources are limited; mental health and substance use disorder continue to impact housing choices as well as the transient nature of some of our beneficiaries. This past quarter, the VCCI began work on integration within the state Coordinated Entry (CE) housing effort – one point of entry for housing resources which stays intact as long as member stays in communication, regardless of where in the state they may be at any point in time. Local partnership agreements for CE are currently being collected and reviewed.

Care Management System

This past year marks the 3rd year that the VCCI team has been functional in the eQHealthCare Management system. System acceptance and CMS certification of the system was achieved. Clinical data from Vermont's Health Information Exchange (VHIE) is viewable within the Care Management system. This allows VCCI case managers to view patient information, as appropriate, to help better inform the case management plan . Users have the ability to see facility visits, Continuing Care Documents, and labs. This past quarter, Admissions | Discharges | Transfers (ADT) messaging from the VHIE became functional with alerts to VCCI case managers on assigned cases that were in the hospital. This allows for point in time collaboration to occur with hospital case managers, and for timely follow up of a hospital stay. During the next quarter, VCCI will work with departmental colleagues to assess if their receipt of ADT messaging on this population is practical. The statewide VCCI also launched obtaining informed consent to VIT, with their assigned members in order to help support information exchange.

Other

A collaborative team of the VCCI, DOC, and DVHA's Chief Medical Officer continue to meet regularly on how best to coordinate treatment for inmates being released from correctional facilities - specifically those with HCV treatment initiated. Current workflows continue to be tested that help to gain efficiencies in information sharing and in the utilization of already purchased prescription drugs. The referral process to VCCI has started with next quarter work to focus on ongoing development of workflow, data collection, and measurement of success. Initial discussion with DOC on how to leverage VCCI's current care management system has begun, with the focus on how eQ can track and monitor the care of inmates in state custody.

ii. Blueprint for Health

Key updates from QE0919:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as evidenced by 136 of Vermont's primary care practices are Blueprint-participating practices. The estimated total number of primary care practices operating in the state is 169, of which an estimated 148 employ more than one provider.
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder. As of September 2019, the number of clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) increased to 3,757, and the number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,173.

Patient Centered Medical Home Program

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. Patient-Centered Medical Home model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each of the state's health service areas. These teams provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The Community Health Team support primary care providers in identifying root causes of health problems, including those with a psychosocial component. They also connect patients with effective interventions, manage chronic conditions, or provide additional opportunities to support improved well-being.

Blueprint Program Managers, who are local leaders in each community, are responsible for contacting all primary care practices within their health service area to encourage, engage, and support practice participation in the Blueprint for Health and learning health system activities. Annually, Program Managers report on the remaining primary care practices in each region that have not begun the process of transforming their practice into Patient-Centered Medical Homes and indicate the rationale provided by each practice contact. Importantly, Blueprint Program Managers report very few practices in each health service area remaining who are not currently engaged with the Blueprint for Health program. In addition to Program Managers, the Blueprint further supports participating practice with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators bring Blueprint generated all-payer data about practice performance (Blueprint Practice Profiles, Blueprint Community Health Profiles) and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA Patient-Centered Medical Home recognition. After recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic

condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These include:

- focusing quality improvement activities on All Payer Model agreement and Accountable Care Organization quality measures;
- integration of the care model;
- implementation of new initiatives (e.g. Spoke program, Women's Health Initiative, improving opioid prescribing patterns);
- prevention and management of chronic conditions (e.g. for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

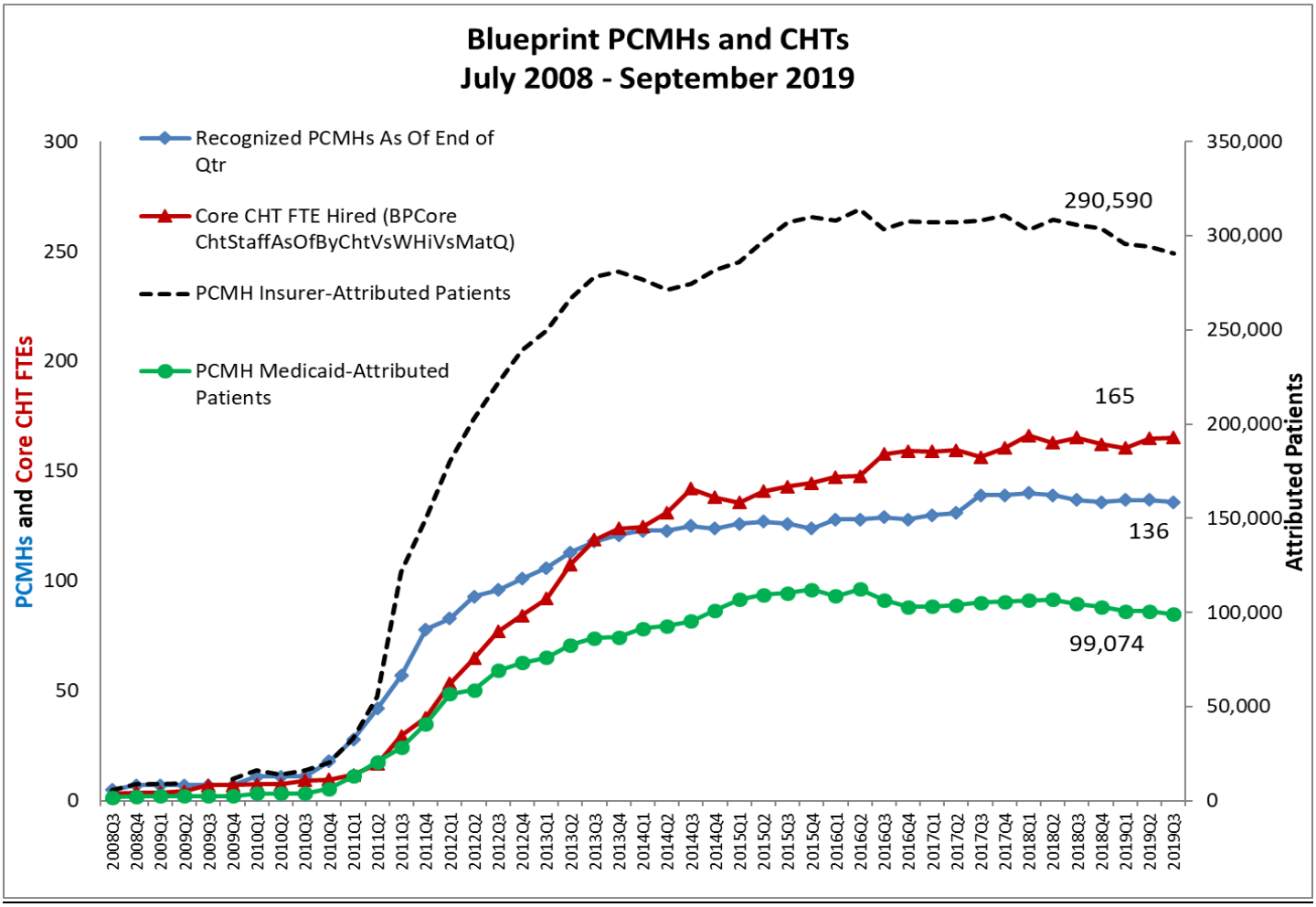
Blueprint-participating Patient-Centered Medical Homes currently serve 290,590 insurer-attributed patients, of which 99,074 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months prior to the date the attribution process is conducted. These practices and patients are supported by 165 full-time equivalents of Community Health Team staff.

Quarterly Highlights

At the end of the 3rd quarter of 2019, 136 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider.

During the first three quarters of 2019, new and renewing practices went through the 2017 NCQA Patient-Centered Medical Home recognition process. This new recognition process has been greatly streamlined and is composed of three tracks based on a practice's history as a Patient-Centered Medical Home.

Figure 1. Patient-Centered Medical Homes (PCMH) and Community Health Teams (CHT)



Practice Health Profiles and Community Health Profiles

The Blueprint for Health supports data-driven population health improvement by producing profiles that describe the health status and health care utilization, expenditures, and outcomes of individuals in each health service area and patients in each Patient-Centered Medical Home. Both practice-level and community-level profiles use all-payer administrative data, clinical outcomes, and survey information for adult and pediatric populations. Practice Health Profiles help practices identify ways that they can better serve their patients.

Community Health Profiles are used by the regional Accountable Communities for Health (Community Collaboratives) and other local workgroups to inform and complement Community Health Needs Assessments and other community data products. These profiles report on the whole population of patients residing in each health service area (the closest possible approximation of "whole population" reporting from available claims data). Some measures are also broken out into three categories: patients attributed to area Blueprint-participating Patient-Centered Medical Homes, patients receiving most of their primary care in a non-Blueprint practice (such as a specialty practice or an out-of-state practice), and patients with no record of a primary care visit within the last two years. The whole-population reporting approach was new in 2018, and feedback suggests it has made the Community Health Profiles more useful. The Community Health Profiles are now part of Vermont's

hospital budget approval process and Health Resource Allocation Plan, both responsibilities of the state's health care regulatory body, the Green Mountain Care Board. Onpoint Health Data continues to produce these profiles. Practice Health Profiles and Community Health Profiles have been distributed to practices and healthcare organizations for the following data time periods:

i. 01/2013 - 12/2013
ii. 07/2013 - 06/2014
iii. 01/2014 - 12/2014
iv. 07/2014 - 06/2015
v. 01/2015 – 12/2015
vi. 07/2015 – 06/2016
vii. 01/2016 – 12/2016
viii. 07/2016 – 06/2017
ix. 01/2017 – 12/2017

Practice Health and Community Health Profiles for the data period 01/2018 – 12/2018 are anticipated to be produced and distributed in November 2019. The Practice Health Profiles for this data period will be in a new format that the Blueprint for Health central office team designed and prototyped with profile users over the past six months. The new format is intended to make practice performance information more accessible to busy providers and practice staff. Practice profiles are sent to the practices directly, while Community Health Profiles
are posted at http://blueprintforhealth.vermont.gov/community-health-profiles.

Hub & Spoke Program

Medication-assisted treatment for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides medication-assisted treatment for opioid use disorder in two settings – regional, specialty Opioid Treatment Programs (OTPs, Hubs), which provide higher intensity treatment and office-based opioid treatment (OBOT, Spokes) in community-based medical practice settings. The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established medication-assisted treatment as an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission and increased social functioning and retention in treatment.

Many of these outcomes were supported by the recent evaluation of Vermont's Hub & Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication-assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (1 registered nurse and 1 licensed mental health clinician per every 100 Medicaid patients receiving medication-assisted treatment) into Spoke practices for a patient-centered, team- and evidenced-based approach to the treatment of opioid use disorder and the provision of Health Home services. Based upon the "significant impact"

demonstrated by the Hub and Spoke system, Vermont is working towards gaining All Payer participation in the Opioid Use Disorder Health Home model.

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication-assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month-by-month towards long-term recovery and improved health and well-being. At the end of the 3rd quarter of 2019, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3,173 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 253 prescribers and 68.5 full-time equivalent Spoke staff, working as teams, across more than 75[1] different Spoke settings (as of September 2019).

Quarterly Highlights

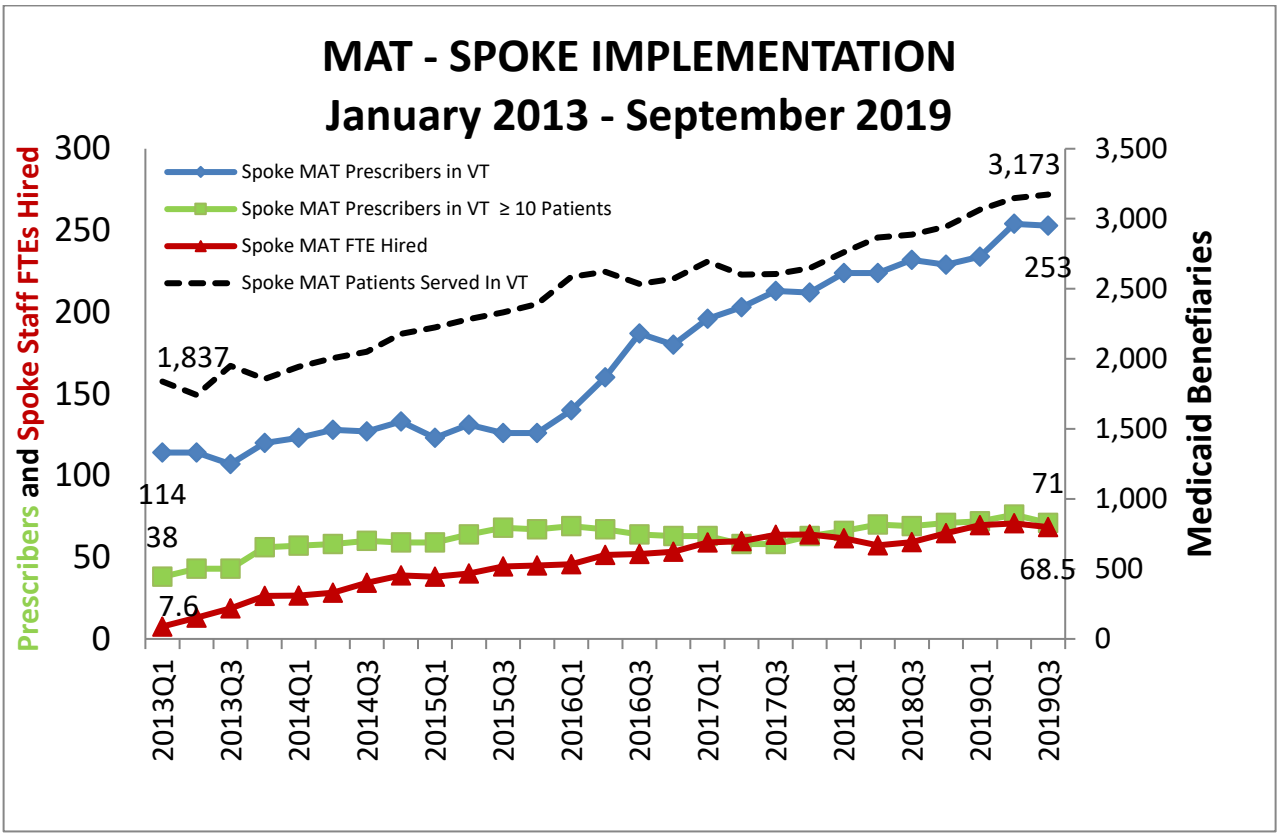
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,757 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of August 2019 and the 3,173 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of September 2019.

- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 75 different spoke settings and by 253 medical doctors, nurse practitioners and physician assistants who work with 68.5 FTE licensed, registered nurses and licensed, Master's-prepared, mental health / substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of September 2019).

- This quarter the Blueprint had an RFP bid selection process for the 2019-2020 MAT Learning Collaborative. The Blueprint has a near-executed contract established with Dartmouth College, expected to begin on November 1, 2019. The 2019-2020 MAT Learning Collaborative will include a series of 5 webinars, 6 regional in-person training sessions, and 1 statewide conference.

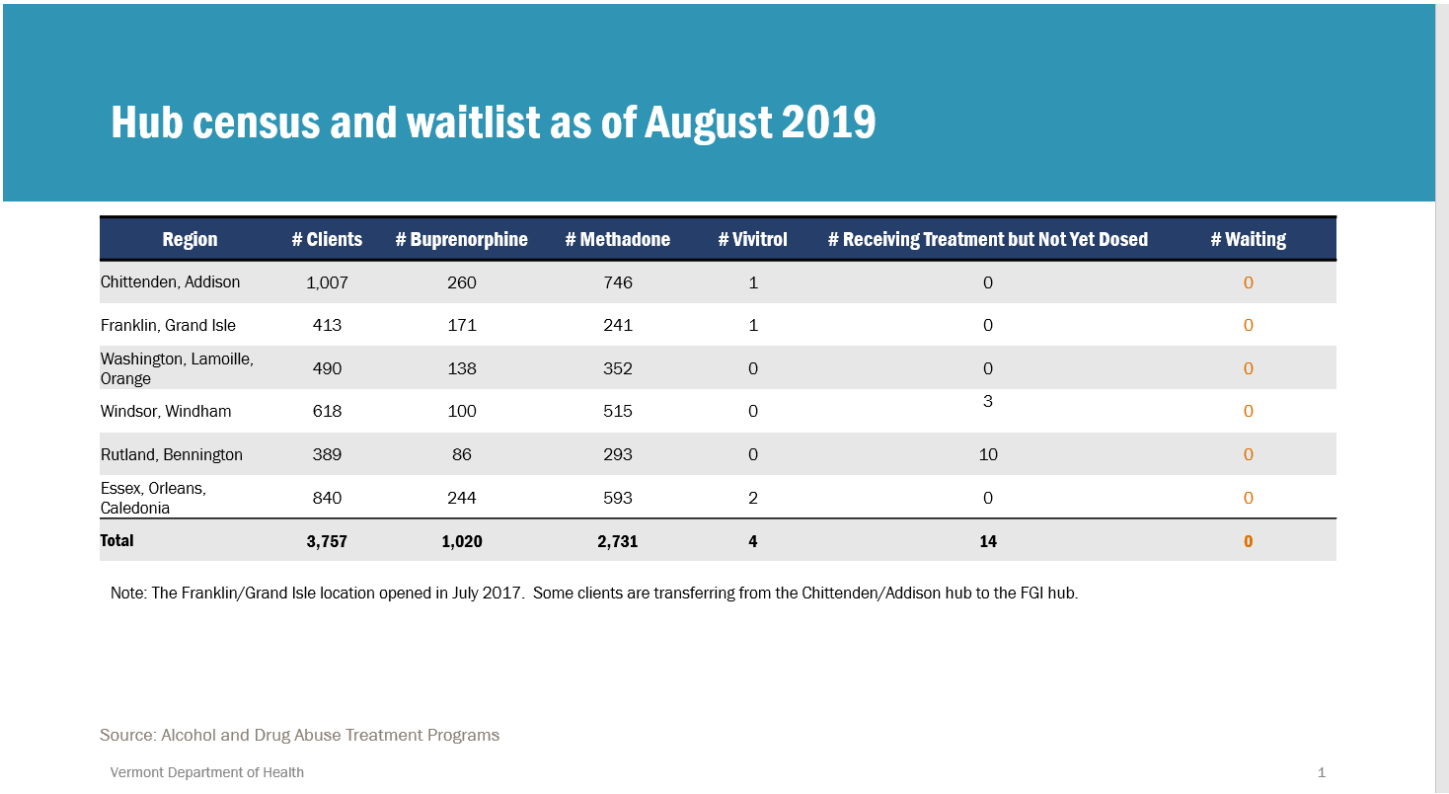
[1] Number of Spoke settings is defined as the number of unique zip codes where there is at least one active Spoke provider.

Figure 2. MAT-SPOKE Implementation January 2013 – September 2019



The table below shows the caseload of regional Hub programs, the number of clients receiving buprenorphine, methadone, or Vivitrol, and indicates that there continues to be no waitlist at any of the regional Hub settings as of the most recent report (August 2019).

Table 1. Hub Implementation by Region as of August 2019



Hub census and waitlist as of August 2019

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	1,007	260	746	1	0	0
Franklin, Grand Isle	413	171	241	1	0	0
Washington, Lamoille, Orange	490	138	352	0	0	0
Windsor, Windham	618	100	515	0	3	0
Rutland, Bennington	389	86	293	0	10	0
Essex, Orleans, Caledonia	840	244	593	2	0	0
Total	**3,757**	**1,020**	**2,731**	**4**	**14**	**0**

Note: The Franklin/Grand Isle location opened in July 2017. Some clients are transferring from the Chittenden/Addison hub to the FGI hub.

Source: Alcohol and Drug Abuse Treatment Programs

Vermont Department of Health 1

Women's Health Initiative

Like the Hub & Spoke program, the Women's Health Initiative began as a challenge from state leadership to improve the health of women and families by addressing the high percentage of unintended pregnancies. Initially, the Initiative was a design project for the Blueprint, in partnership with the Vermont Department of Health and other policy makers, providers, and experts, and subsequently developed into a statewide intervention that now helps Vermonters with accessing evidence-based care.

The Women's Health Initiative offers participating providers and practices new training, staffing, payments, and community connections. With these supports, practices can now offer women enhanced preventative care, screenings and follow-up to address health and social risks, comprehensive family planning counseling, and timely access to the most effective forms of contraception, including Long Acting Reversible Contraceptives (LARC), when chosen by the patient and clinically appropriate. Women who visit Women's Health Initiative-participating women's health practices (OB-GYN offices, midwifery practices, and family planning clinics) and primary care practices engage in enhanced psychosocial screening for mental health and substance use disorders, interpersonal violence, and access to housing and food.

Women identified as at-risk are immediately connected to a licensed mental health clinician for brief intervention, counseling, and referral to more intensive treatment as needed. The clinicians connect women with their local network of health, social, economic and community services. Women also engage in comprehensive family planning counseling at participating practices and community-based organizations. Women who wish to become pregnant receive pre-conception counseling and services to support the healthiest pregnancies possible. For those women who indicate they do not want to have a baby in the coming year, they have access to the full spectrum of contraception options, including immediate access to LARC.

The payments associated with participating in the Women's Health Initiative support women's health and primary care practices in designing workflows that support the enhanced psychosocial screening, comprehensive family planning counseling, and same-day LARC insertion and support the provision of effective interventions by licensed mental health clinicians. A key aspect of the initiative is the focus on improving clinical-community linkages, which involves collaboration between participating practices and community-based organizations in order to successfully address health care and non-medical health related social needs. Communities that have practices participating in the Women's Health Initiative have developed coalitions that include the participating medical practices and community organizations in order to develop bidirectional referrals pathways that support Vermonters with accessing necessary services more efficiently.

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 38 practices (20 women's health and 18 primary care) to participate in the Women's Health Initiative as of September 2019.

- In August $23,486 was distributed to four practices as a one-time payment to support the implementation of the WHI in those areas.

- The Women's Health Initiative (WHI) is approaching statewide coverage, as all but two Hospital Service Areas have a specialized women's health practice now participating in the WHI. In September an additional practice joined the program: Community Health Centers of Burlington-Safe Harbor. Furthermore, continued expansion of the WHI is expected among Planned Parenthood of Northern New England women's health practices and within Blueprint Patient-Centered Medical Homes.

Figure 3. Women's Health Initiative: Practices, Patients, and Community Health Team (CHT) Staffing

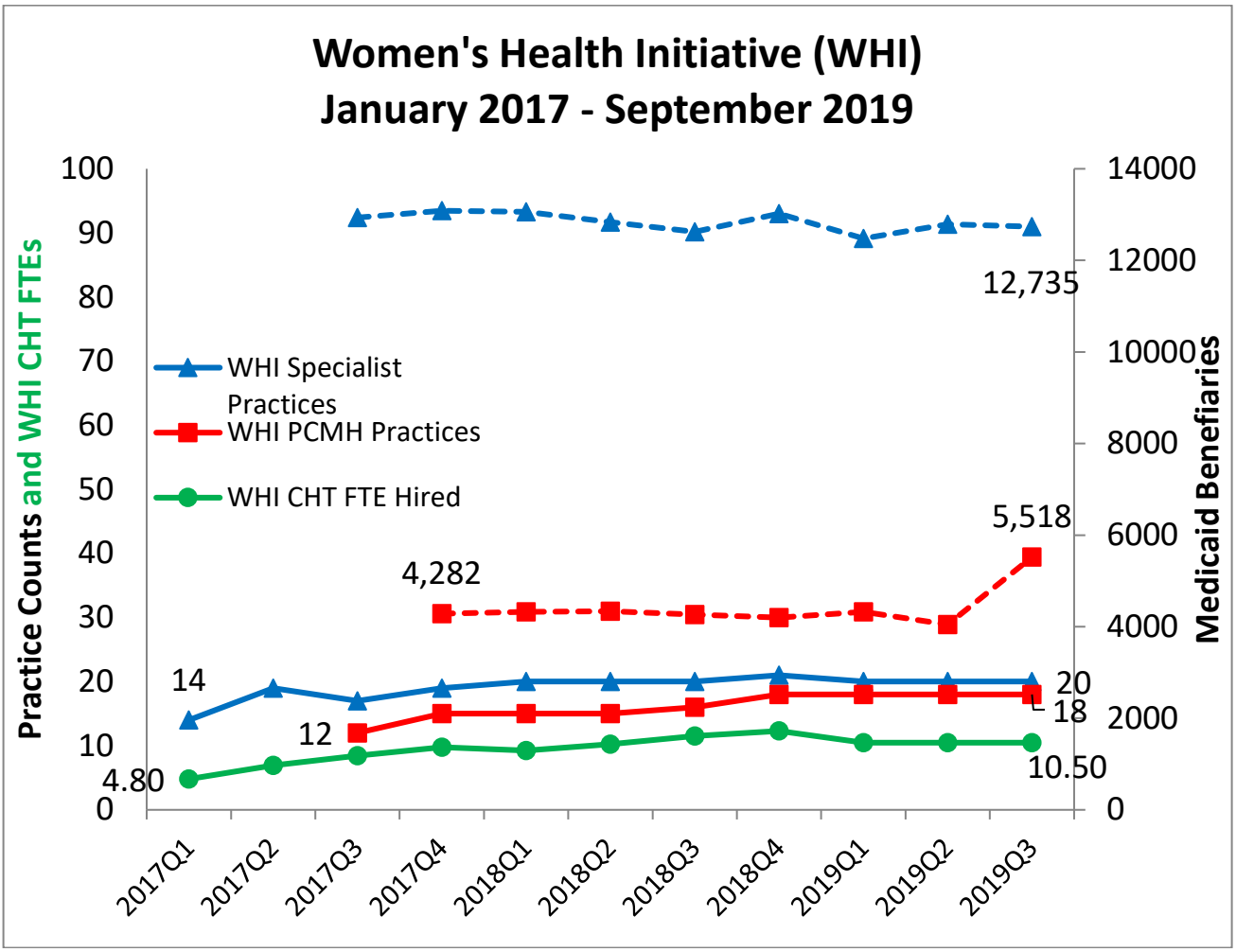


Table 2. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of September 2019	WHI PCMH Practices as of September 2019	WHI CHT Staff FTE Hired as of September 2019	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of September 2019	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of September 2019
Barre	1	1	1.00	1314	508
Bennington	1	2	0.50	1024	266
Brattleboro	1	0	1.00	591	0
Burlington	3	6	3.00	6014	4076
Middlebury	1	0	0.75	1123	0
Morrisville	1	2	0.50	579	474
Newport	0	0	0.00	0	0
Randolph	2	0	0.50	521	0
Rutland	1	1	1.50	1756	189
Springfield	1	4	1.00	504	1528
St. Albans	1	0	0.00	1193	0
St. Johnsbury	1	2	0.75	903	704
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	6	0	N/A	4563	0
Total	20	18	10.50	15521	7745

*The Windsor Health Service Area does not have women's health specialty practices.
**Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.

iii. Behavioral Health

Key updates from QE0919:

- Pilot Project Analysis and Extension
- Emergency Department collaboration
- Team Care program revisions
- Applied Behavior Analysis
- Onboarding providers

In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, DVHA is in year three of a pilot project in which there is automatic initial authorization of 5 days for all members meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each member admitted. Qualitative reviews on a large sample of pilot project authorizations are conducted quarterly to ensure appropriate utilization. The reviews have found that the admissions would have been authorized under the previous system. There continues to be a decline in the average lengths of stay. This decrease allows for an increase in access and may be attributable to a stronger focus on discharge planning upon admission. There has also been a significant decrease in contested authorization decisions. The pilot project was extended through December 31st, 2020. Close monitoring and quarterly qualitative reviews continue with similar results. The team is also evaluating whether members attributed to the Accountable Care Organization (ACO) have similar average lengths of stay. This quarter, data indicates that the average length of stay for ACO attributed members and Non-ACO attributed members is similar on average.

In an effort to reduce the number of members waiting in emergency departments for placement, staff from the quality unit joined colleagues from other departments to develop a system for identifying and supporting transition. A system has been established to identify members waiting in emergency departments with disposition issues, and DVHA is notified and collaborates with partners as necessary. This quarter, there have been minimal instances in which DVHA was contacted for support regarding these cases.

The Behavioral Health Team also manages the Team Care program (the lock-in program). The annual review of clinical documentation and data has been completed in order to support ongoing member inclusion in the program. The team identifies members who may no longer need the structure of the program and can potentially be disenrolled. The team conducted a complete review of Team Care protocol. Standards (objective and subjective) for inclusion and disenrollment were defined and operationalized by the team. A Standard Operating Procedure was developed, and staff have been trained on the new procedure. The practice of referring Team Care program members to VCCI when appropriate has been incorporated in the protocol. New methods for identification of potential members are being explored. Claims data has been queried and new potential referrals have been identified and are being reviewed by the team for appropriateness for possible enrollment. There were no new members enrolled to Team Care this quarter, with only one internal VCCI referral of a member who did not meet criteria for enrollment. The lack of referrals this quarter may indicate the impact of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS. The team is also developing a method to more accurately assess cost savings attributable to inclusion in the Team Care program.

The Unit also manages the Applied Behavior Analysis (ABA) benefit. The unit collaborated with Payment Reform Unit, Policy Unit and AHS sister departments to explore opportunities for changing the current payment method for ABA. A tiered rate was developed with a start date of July 1, 2019. Providers receive a prospective case rate for services delivered. Providers have successfully received payments during this first quarter. The goal of this payment reform project was to increase utilization and access to services; since July, 40 new members have begun receiving ABA services. Site visits to ABA facilities will begin in January 2020. The QICI Autism Specialist participates in the Autism Workgroup, which is held on a bi-monthly basis and includes community partners, including several ABA providers across the State. This meeting gives ABA providers the opportunity to ask questions and allows them to provide feedback directly to the Autism Specialist. Ongoing collaboration with sister departments has allowed for coordination of services and increasing supports to Medicaid members. DVHA continues to identify and onboard providers specializing in services for children with autism.

The Unit has been actively working to onboard new Vermont Medicaid providers and have been working to build upon existing relationships with current providers. The Unit is identifying facilities/providers to onboard and plan to visit these sites within the next year. Additionally, the unit has partnered with the DVHA Provider Member Relations Unit to assist with enrollment site visits. The goal is to assist Provider Member Relations with site visits specific to behavioral health facilities/providers.

iv. Mental Health System of Care

Key updates from QE0919:

- 1115 Demonstration Waiver Amendment Request
- Listening Tour and Mental Health "Think Tank"
- Delivery System and Payment Reform
- Integrating Family Services updates

System Overview

The Department of Mental Health (DMH) is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of:

- Community Rehabilitation and Treatment (CRT) services for adults with severe and persistent mental illness;
- Adult Outpatient for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions;
- Emergency Services for anyone, regardless of age, in a mental-health crisis; and
- Children, Youth, and Family Services, including children who have a serious emotional disturbance and their families.

DMH also contracts with several peer and family-run organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside of the Designated Agencies in their catchment area. Peer and family-run organizations also help educate individuals and families to advocate for their needs within the Designated Agencies and across multiple service provider organizations.

Inpatient care is provided through a decentralized system which includes one state-run psychiatric care hospital and five Designated Hospitals located across the state.

Community services support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided closer to individuals' homes.

Updates

On August 1, 2019 the Agency published a public notice of the intent to submit an 1115 waiver Demonstration Amendment Request to CMS in accordance with the SMI/SED opportunity described in the November 13, 2018 SMDL and as specified in Vermont's formal request submitted on January 29, 2018.

Stakeholder Engagement

During the third quarter the Department of Mental Health completed the first phase of a robust stakeholder engagement process that will inform the creation of a 10-year vision for the mental health system of care spanning children, youth, families and adults, accompanied by clear action steps for achievement.

The Department began the stakeholder engagement process in June, traveling around the state to Rutland, Burlington, St. Johnsbury, Randolph, and Brattleboro for a total of 10 listening sessions by the end of August. More than 300 people attended those sessions, in which Department staff facilitated small group discussions in order to get detailed input on what Vermont's future mental health system of care should be – what it should look like, how it should function, what the priorities should be and more.

The Department of Mental Health next kicked off its mental health "Think Tank", which is comprised of people with lived experience, peer support specialists, providers, legislators and others interested in the mental health system of care. The Think Tank will meet a total of 5 times over this fall and early winter in order to create the contents of a 10-year plan for mental health. The plan will include short term, mid-term and long-term strategies for the system of care that support goals identified by Vermonters during the Listening Tour and will be delivered to the legislature in January, 2020.

Payment Reform

As part of the State's efforts to develop health care payment and delivery system reform models that align with Vermont's All-Payer ACO Model agreement and advance implementation of Vermont's Global Commitment to Health waiver, DMH has worked with other departments in the AHS and with stakeholders to design and implement a payment model for children's and adult mental health services provided by Designated and Specialized Services Agencies (Mental Health Clinics). DMH

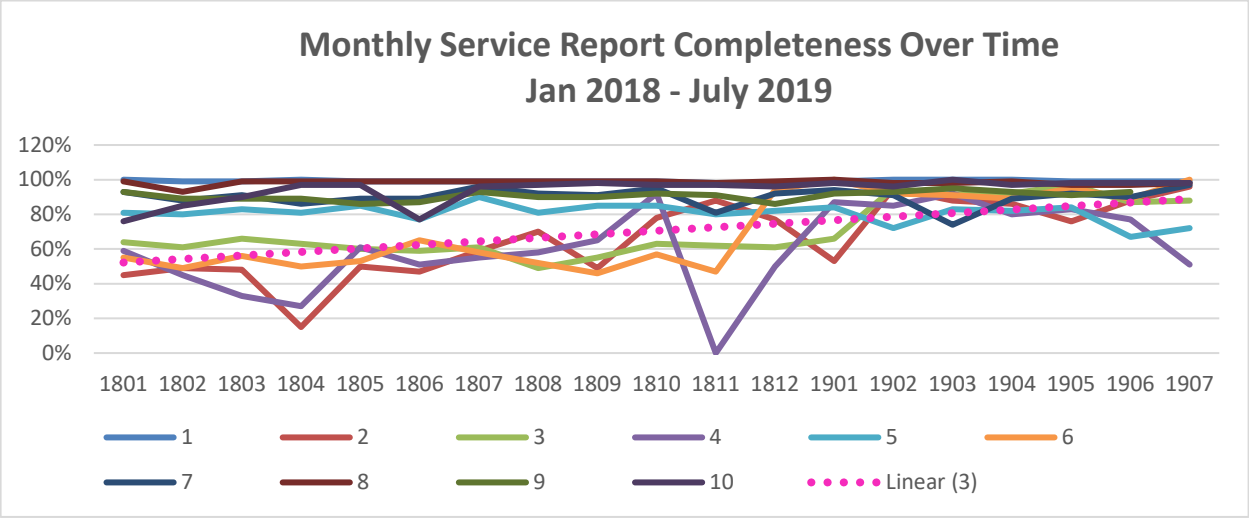
successfully executed all Agreements necessary for implementation on January 1, 2019 and has spent the first three quarters of the calendar year providing technical support to providers and monitoring for potential implementation issues.

This alternative payment model is intended to improve the predictability of payments to providers of mental health services, and to increase their flexibility to meet the needs of the Vermonters they serve. The new model places additional focus on quality—at first by providing an incentive for providers to report complete, accurate, and timely information, and in the future by linking a portion of payments to providers' performance on certain quality measures. The new payment model shares many characteristics of other value-based payment models that the State is implementing or considering for future implementation; such alignment should contribute to both State and provider readiness for an increasingly integrated health care delivery system over time and should aid the State in developing a strategy for inclusion of additional services in All-Payer financial targets in future.

During the third quarter, the Department began work on a new rate adjustment tool with the intention to implement rate adjustments for July of 2020.

Due to the timing of this third quarterly report, the fully updated chart of achievement of value-based payment process measures will need to be included in the next quarterly report. However, preliminary analysis of performance in CY2019 show that process measures have been effective in achieving the Department's goals for data quality and timeliness.

Figure 4. Improvement in Monthly Service Reporting Completeness



Integrating Family Services

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle (this provider is both the Designated Agency and Parent Child Center). This has created a seamless system of care to

ensure no duplication of services for children and families.

Beginning on January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS including having incentives tied to them in alignment with statewide implementation. At the same time, IFS regions have additional requirements for performance measurement in accordance with the broader scope of services included in those regions. Vermont submitted a multiyear payment model for consideration to CMS in September 2018 and received approval in late December.

As part of quality oversight, this calendar year both the Addison and Franklin/Grand Isle sites had integrated quality chart reviews. This review occurs every two years and includes an interagency team from AHS doing a minimum standards chart review across all funding streams that are included in the IFS case rates in addition to mental health funds-this includes the Department of Health, Child Development Division, Family Services Division, and Developmental Services. This process results in a report being issued that focuses on their strengths and areas that need improvement or corrective action. Both regions had showed improvements from the previous review with only a few areas identified needing a quality improvement plan.

Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. The data in both regions is being used to launch population health efforts to do more prevention and promotion work-a key goal of having the flexibility within bundled payments. As well, both regions are also working on implementing the Adult Needs and Strengths Assessment (ANSA) which will become part of value-based payments starting in January, 2021.

v. Pharmacy Program

Key updates from QE0919:

- The Drug Utilization Review Board (DURB) held one meeting this quarter.
- Bulletins and Advisories

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly-funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals, controlling pharmacy expenditures through managing cost, brand and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide an array of operational, clinical, and programmatic support in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages over $185 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing - enforcing coverage rules for various program.
- Pharmacy provider assistance - DVHA, Change Healthcare Technical and Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Maximus to resolve issues. Vermont Department of Health (VDH)-Vaccine Program, Substance Abuse Program, Department of Mental Health (DMH) management of antipsychotics.
- Works with Vermont Medication Assistance Program (VMAP)and Children with Special Health Needs (CSHN) to assist in the management of the programs.

Clinical

- Manages drug utilization and cost
    - Federal, State, Supplemental rebate programs
    - Preferred Drug list
    - Drug Utilization Review/Pharmaceutical & Therapeutics Board activities
        - therapeutic class reviews, prior authorization criteria reviews and step-therapy protocols
        - Specialty Pharmacy
- Manages exception requests, second reconsiderations, appeals and fair hearings with the Policy Unit
- Works with Program Integrity Unit on drug utilization issues

Bulletins and Advisories/Communications

The following communications were sent to pharmacies and providers:

1. **Updated Implementation Date – Important Changes to Administration Fee for Vaccines**

The following communication was sent on 09/27/19 with an effective date of 10/11/19. The revised effective date is 11/08/19.

The pharmacy administration fee for the influenza vaccine will be changing from $16.71 to $13.97. The adjustment is being made to align with changes to the physician fee schedule (CPT code 90471) for adults.

Covered influenza vaccines for the 2019/2020 season include:

- Afluria® (Quadrivalent)
- Fluarix® (Quadrivalent)
- FluLaval® (Quadrivalent)
- Fluzone® (Quadrivalent)

Additionally, DVHA is pleased to announce that a vaccine administration fee of $13.97 will apply to all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for the following vaccines:

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papilloma Virus (HPV)
- Measles, Mumps and Rubella (MMR)
- Meningococcal
- Pneumococcal
- Tetanus and Diphtheria
- Tetanus, Diphtheria and Pertussis
- Typhoid Fever
- Varicella

DVHA enrolled pharmacies may be reimbursed for vaccinations administered by pharmacies to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacies must be certified to administer vaccines in the State of Vermont and must be compliant with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment. Children age 6 months through 18 years presenting for vaccination at pharmacies should be referred to their health care provider for State-supplied vaccines.

Reimbursement will be based on either a written prescription or a non-patient specific written protocol based on a collaborative practice agreement per state law. These orders must be kept on file at the pharmacy. Through the pharmacy point-of-sale (POS) system, the pharmacy must submit the code MA in the Professional Service Code field in order to receive full reimbursement. There is no dispensing fee paid for pharmacist-administered vaccines.

2. **DVHA Preferred Drug List (PDL) Changes**

This notice contains October 11, 2019 changes to the Vermont Medicaid Preferred Drug List:

Moved to Preferred Status:

- Testosterone1.62% Gel Packets
- Testosterone 1.62% Gel Pump
- Fluticasone/Salmeterol inhalation powder (compare to Advair® Diskus) (authorized generic, Prasco labeler code 66993 is the **only preferred form**)
- Spiriva® Respimat (tiotropium)
- Xerax-AC (aluminum chloride) 6.25% Solution

Moved to Non-Preferred Status:

- Androgel® Pump (testosterone pump bottles)
- Advair® Diskus (fluticasone/salmeterol)
- Albuterol HFA (compare to Proventil® HFA, ProAir® HFA, Ventolin® HFA)

- Androgel® 1.62% Gel Packets (testosterone)

NOTE: Androgel 1% packets, Proventil HFA and ProAir HFA will remain Preferred

In addition, the DURB reviewed the following newly marketed drugs:

- Apadaz® (benzhydrocodone and acetaminophen)
- Firdapse® (amifampridine)
- Gamifant® (emapalumab-lzsg)
- Inbrija® (levodopa inhalation powder)
- Lexette® (halobetasol propionate)
- Motegrity® (prucalopride)
- Nuzyra® (omadacycline)
- Spravato® (esketamine nasal spray)
- Qbrexza® (glycopyrronium
- Seysara® (sarecycline tablets)
- Wixela™ Inhub™ (fluticasone/salmeterol inhalation powder) (compare to Advair® diskus
- Symjepi® (epinephrine**)**

To review the complete PDL please refer to:

http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria

3. **Important Changes to Coverage for Continuous Glucose Monitoring (CGM) Systems and Supplies**

Effective 10/01/19, preferred Continuous Glucose Monitoring (GCM) systems and supplies will be available at retail pharmacies in addition to current DME providers. Prescribers may send prescriptions electronically to the pharmacy or hand write a prescriptions for patients. Claims will adjudicate in "real time" through the Pharmacy Point-of-Sale (POS) system which will allow for faster and more efficient access for patients.

The process for prior authorization (PA) submissions and the clinical criteria for use is also changing. The criteria and PA forms are posted on the DVHA website at: http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria/view. Regardless of whether you choose to use a retail pharmacy or DME provider, all prior authorization requests must be submitted via fax to Change Healthcare at 844-679-5366. Prior authorization is required for both new and existing patients and will apply to all CGM supplies including transmitters, receivers and sensors. Please note that many new devices do not require the use of a separate receiver and patients may prefer to use a "smart device" such as a cell phone, in lieu of a receiver.

Providers' patients that have a current PA on file that wish to transition from a DME provider to a retail pharmacy provider (pharmacy benefit) should contact Change Healthcare by phone to help ensure a smooth transition and minimize provider burden.

HCPC codes affected by the change: A9276-Sensor, A9277 – Transmitter and A9278-Receiver (Monitor)

Effective 10/01/19, the following products will be available through pharmacies and DME providers, pending PA approval:

PRODUCT NAME	**NATIONAL DRUG CODE (NDC)**	**QUANTITY LIMITS**
Freestyle Libre (10-day) Sensor	57599-0000-19	9 sensors per 90 days
Freestyle Libre (10-day) Reader	57599-0000-21	1
Freestyle Libre (14-day) Sensor	57599-0001-01	6 sensors per 84 days
Freestyle Libre (14-day) Reader	57599-0002-00	1
Dexcom G6 Transmitter	08627-0016-01	1 per 90 days
Dexcom G6 Sensor	08627-0053-03	9 sensors per 90 days
Dexcom G6 Receiver	08627-0091-11	1

The following NDC's will continue being dispensed via medical/DME channels only, pending PA approval:

PRODUCT NAME	**NATIONAL DRUG CODE (NDC)**	**QUANTITY LIMITS**
Medtronic Enlite Sensors (for use with the MM530G and Revel Pumps)	76300-0008-05	
Medtronic Guardian Sensor (for use with MM630G and	43169-0704-05	

MM670G pumps and the Guardian Connect		
Medtronic MiniLink Transmitter (includes Enlite serter)	76300-0725-01	1 per 90 days
Medtronic 630G Guardian Press Starter Transmitter Kit	43169-0800-40	1 per 90 days
Medtronic 670G Guardian Link 3 Transmitter Kit	43169-0955-68	1 per 90 days
Medtronic Guardian Connect Transmitter	76300-0002-60	1 per 90 days

A 72 hour short term CGM trial is no longer required. The PA will be removed for the following CPT codes: 95249, 95250, 95251.

Drug Utilization Review Board

The Drug Utilization Review Board (DURB) was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DUR program to:

1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews;
2) Apply these criteria and standards in the application of DURB activities;
3) Review and report the results of DUR programs; and
4) Recommend and evaluate educational intervention programs.

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to three - year terms with the option to extend to a six - year term. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Drug Utilization Review Board meetings occur seven times per year. In QE0919, the DURB held one meeting. The DURB is scheduled to hold two meetings next quarter. Information on the DURB and its activities in 2019 is available at this link: http://dvha.vermont.gov/advisory-boards.

Drug Utilization Review Board Meetings

Eleven new drugs and no therapeutic drug classes were reviewed at the DURB meeting held this quarter; one RetroDur review and one safety alert was also presented.

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0919:

- DVHA completed financial reconciliation activities for the 2018 performance year and notified stakeholders of final 2018 program results for quality performance.
- DVHA and OneCare continued contract negotiations for the 2020 performance year.
- Future program implementation will continue to be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

In 2016, the Department of Vermont Health Access (DVHA) sought to establish service agreements with one (or more) Accountable Care Organization(s) (ACOs) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model. As an evolution of the *Vermont Medicaid Shared Savings Program* (VMSSP), this new program offering creates a structure for provider organizations and other suppliers to join together under an ACO to voluntarily contract with DVHA to assume accountability for the cost and quality of care for Vermont's Medicaid beneficiaries, and for ACOs to distribute payments to their contracted network providers for any covered services rendered on behalf of Vermont Medicaid beneficiaries using alternatives to fee-for-service reimbursement. The goal of this agreement is to improve the quality and value of the care provided to the citizens served by the State of Vermont's public health care programs.

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities participated in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: The University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

DVHA issues a prospective Per-Member-Per-Month (PMPM) payment to the ACO; the ACO distributes payments to providers participating in the program per contractual arrangements between the ACO and providers. The ACO is paid for each attributed member according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed member. Payments for services not included in the ACO contract continue to be paid fee-for-service, as are payments made to Medicaid providers not participating in the ACO's network.

DVHA and OneCare executed a contract amendment to extend the VMNG program into a 2019 performance year. A notable adjustment to the VMNG program for 2019 was to the methodology by which members are attributed to the model, to more accurately reflect relationships between members and providers. Additionally, a pilot geographic attribution methodology was put into place for one VMNG-participating Health Service Area (HSA), through which all Medicaid members are attributed to the ACO based on their residence in that HSA. This pilot will be studied throughout 2019 to assess

whether expanding a geographic approach to attributing members to the program is feasible to expand to other HSAs in the state. Other programmatic changes were minimal, as the primary focus for the 2019 year continues to be on growing the model and expanding the number of participating providers and attributed members, while maintaining alignment across payer programs as part of Vermont's All-Payer ACO Model. The number of risk-bearing hospital communities increased from ten to thirteen for the 2019 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2019 performance year increased from approximately 42,000 lives to approximately 79,000 lives.

DVHA completed financial reconciliation activities for its 2018 performance year in mid-September 2019. Results were released on September 20, 2019. OneCare spent $1.5 million more during the program year than its expected total cost of care and will return those funds to DVHA. OneCare demonstrated a quality score of 85% on 10 payment measures from its measure set, and the results did not differ significantly from performance in the prior year. Some measures continue to present a good opportunity for improvement in future years. Further information regarding the VMNG's 2018 performance can be found here: https://dvha.vermont.gov/administration/1final-vmng-2018-report-09-20-19.pdf.

DVHA entered into contract negotiations with OneCare for the 2020 performance year in mid-Q2 of 2019 and negotiations are ongoing as of the end of Q3 2019. The main potential changes to the program for the 2020 performance year focus on the development of a more inclusive attribution methodology that builds on its 2019 geographic attribution pilot. Other anticipated programmatic changes are minor. Negotiations are expected to continue into Q4 of 2019, after which further detail of changes to the model will be available.

DVHA and OneCare continue discussions of potential modifications for future program years, while remaining focused on aligning programs across payers in support of broader All Payer Model efforts.

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the September 2019 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC). After each quarterly submission, AHS reconciles the amount claimed on the CMS-64 versus the monthly payments made to DVHA.

The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and administration) for the given quarter. AHS submitted and certified the CMS64 report for QE0919 on October 30, 2019, as is normal. An Investment adjustment of ($78,762) for QE0918 was entered to reduce CY2018 investments total so it did not exceed the maximum CY2018 amount.

During QE0919, AHS corrected the Budget Neutrality (BN) PMPMs in the worksheet because it was found there was a version-control issue during the 2016 renewal so that the STCs do not reflect the final BN worksheet amounts. The most significant issue is the ABD-Non-Medicare- Child PMPMs. At the end of the negotiations, the state needed to "back-out" the Woodside (non-PRTF) costs for the ABD Non-Medicare Child Eligibility Group to ensure assure that the STCs capture the final BN Agreement.

AHS and DVHA had discovered a discrepancy in the assignment of Medicaid Eligibility Group (MEG) for some of our members. There are approximately 450 members that had been erroneously counted in the ABD member month count, while their costs had been reported in the non-ABD group for the CMS64. AHS adjusted the member month count for these members during QE0919 so they are properly accounted for in the non-ABD group. Although this has budget neutrality implications, AHS does not anticipate it will be significant.

AHS has observed that expenditures for the SUD IMD group are currently exceeding the PMPM without waiver projections shown on the supplemental SUD IMD budget neutrality test. The following trends have been observed: The lowest enrollment was observed in January 2019 and the highest enrollment was observed in August of 2019. The average monthly enrollment is 191.
The SUD quarterly expenditures have grown steadily in the last two quarters. AHS will further investigate claims data that could further explain the variance we are seeing on the budget neutrality test.

Figure 5. SUD Monthly Enrollment

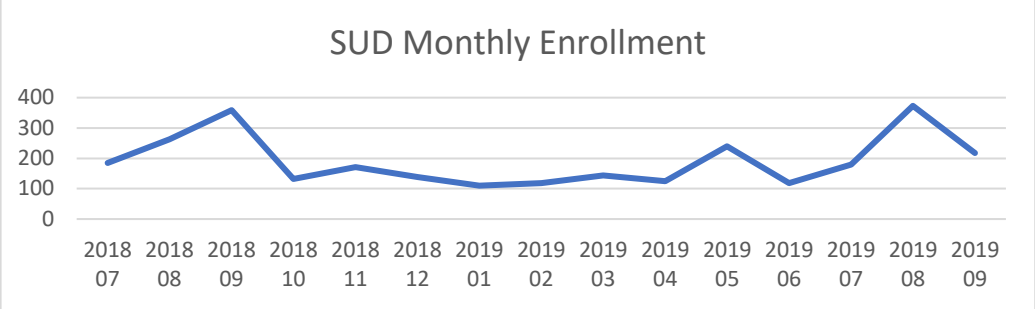
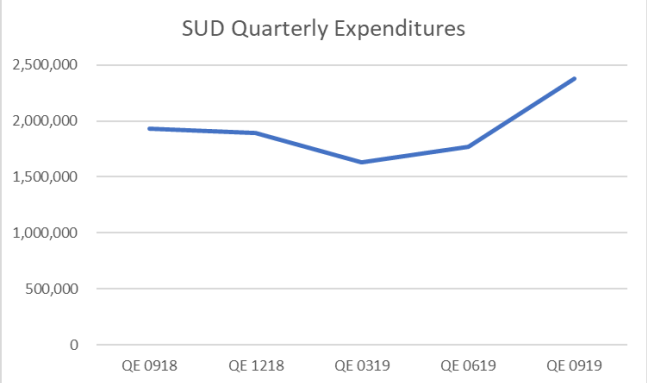


Figure 6. SUD Quarterly Expenditures



DVHA and AHS have completed the CY2017 medical loss ratio (MLR) calculation and will be submitting to the CMS Regional Office for review. DVHA is prepared for CY 2018 MLR and has an SOP in place.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0919 was $25,647,968. There was no spending for Delivery System Reform Investments. CY2019 marks

the first year in which room and board and physician training program Investments must be phased down by 33%. The HIT and non-State plan related Education fund Investments have already been fully phased-down.

VI. Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced as of the 15th of every month. The member months are subject to revision over the course of a twelve-month period due to a beneficiary's change in enrollment status.

The table below contains Member Month Reporting for QE0919 of CY2019 and includes the unduplicated count of member months for SUD IMD stays. CY2018 and CY 2017 member months are also reported in the tables below.

Table 3. Member Month Reporting – Calendar Year 2019, QE0919, *subject to revision*

Demonstration Population	Medicaid Eligibility Group	Total CY 2019
1, 4*, 5*	ABD - Non-Medicare - Adult	**61,350**
	SUD - IMD - ABD	**108**
1	ABD - Non-Medicare - Child	**18,498**
1, 4*, 5*	ABD - Dual	**192,400**
	SUD - IMD - ABD Dual	**118**
2	ANFC - Non-Medicare - Adult	**79,842**
	SUD - IMD - ANFC	**170**
2	ANFC - Non-Medicare - Child	**529,430**
	Medicaid Expansion	
7	Global RX	**58,323**
8	Global RX	**33,531**
6	Moderate Needs	**1,629**
	New Adults	
3	New Adult with out child	**320,975**
	SUD - IMD New Adult w/o child	**1,028**
3	New Adult with child	**174,842**
	SUD - IMD New Adult with child	**201**
	Total	**1,472,445**
*** Long Term Care Group**	**Total CY 2019**	
4 only	ABD Long Term Care Highest Need	**26,156**
5 only	ABD Long Term Care High Need	**11,373**

Demonstration Population	Medicaid Eligibility Group	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	**83,074**
	SUD - IMD - ABD	**78**
1	ABD - Non-Medicare - Child	**25,577**
1, 4*, 5*	ABD - Dual	**257,257**
	SUD - IMD - ABD Dual	**78**
2	ANFC - Non-Medicare - Adult	**143,380**
	SUD - IMD - ANFC	**187**
2	ANFC - Non-Medicare - Child	**723,123**
	Medicaid Expansion	
7	Global RX	**79,489**
8	Global RX	**46,792**
6	Moderate Needs	**2,319**
	New Adults	
3	New Adult with out child	**471,885**
	SUD - IMD New Adult w/o child	**791**
3	New Adult with child	**223,882**
	SUD - IMD New Adult with child	**114**
	Total	**2,058,026**
*** Long Term Care Group**	**Total CY 2018**	
4 only	ABD Long Term Care Highest Need	**34,855**
5 only	ABD Long Term Care High Need	**14,056**

Demonstration Population	Medicaid Eligibility Group	Total CY 2017
1, 4*, 5*	ABD - Non-Medicare - Adult	**94,629**
1	ABD - Non-Medicare - Child	**28,865**
1, 4*, 5*	ABD - Dual	**255,478**
2	ANFC - Non-Medicare - Adult	**157,964**
2	ANFC - Non-Medicare - Child	**730,744**
	Medicaid Expansion	
7	Global RX	**84,049**
8	Global RX	**47,561**
6	Moderate Needs	**2,960**
	New Adults	
3	New Adult with out child	**490,537**
3	New Adult with child	**224,721**
	Total	**2,117,508**
*** Long Term Care Group**	**Total CY 2017**	
4 only	ABD Long Term Care Highest Need	**35,052**
5 only	ABD Long Term Care High Need	**13,202**

Table 4. PMPM Capitated Rates CY 2019

	includes SUD	
	1/1/2019-12/31/2019	
Medicaid Eligibility Group		
ABD Adult	**$**	**2,115.84**
ABD Child	**$**	**2,668.98**
ABD - Dual	**$**	**1,787.87**
non-ABD Adult	**$**	**590.64**
non-ABD Child	**$**	**464.71**
GlobalRx	**$**	**103.91**
New Adult	**$**	**463.29**
Moderates	**$**	**512.98**

VII. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the Office of the Health Care Advocate (HCA) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 5). These include inquiries, requests for information, and requests for assistance. The HCA's role is to advocate for all Vermonters by providing individual consumer assistance and consumer advocacy on issues related to health insurance and health care.

VIII. Quality Improvement

Key updates from QE0919:

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment. DVHA received a score of 100% on our annual PIP summary submission to our EQRO.
- Quality Unit staff continued to coordinate the chlamydia screening learning collaborative.
- The Quality Committee completed its annual review of the MCE's Global Commitment to Health Core Performance Measure Set.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers. The unit is responsible for instilling the principles of quality throughout DVHA; supporting the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

Managed Care Entity (MCE) Quality Committee

The MCE Quality Committee consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and containing the cost of health care. During this most recent quarter the full committee met twice and the clinical sub-committee met once. In July the full committee completed its discussion about the addition of questions to the 2019 CAHPS experience of care survey tools and began its annual review of the Global Commitment to Health Core Performance Measure Set. In order to further that discussion at the full group meeting in September, a clinical sub-group met in July to review and revise the Core Set measure targets. The performance measure set review was then completed at the full committee's September meeting. A short list of possible quality improvement topic ideas were generated. As the state moves closer to full VMNG ACO Medicaid member attribution, this committee's recommendations may be passed along to OneCare through the joint Quality work group.

Medicaid ACO Monitoring and Operations

Quality Unit staff participate in two workgroups that are responsible for monitoring the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO). A group of staff from around the Department who receive and review the required ACO reporting meet on a monthly basis. DVHA's Quality Improvement Administrator reviews the Quality Management report submitted by OneCare each quarter. The group believes that a coordinated internal review increases the opportunity to identify gaps/areas of concern.

The DVHA Quality Unit also meets quarterly with the OneCare VT Quality team for a more targeted quality management review, often with a focus on coordinating quality improvement efforts. During the most recent reporting period our teams met in August. Discussion topics included the VMNG Value Based Incentive Fund Quality Improvement Projects, learning collaboratives and quality measure scorecards.

Formal CMS Performance Improvement Project (PIP)

The Quality Unit continues to coordinate VT Medicaid's formal CMS Performance Improvement Project (PIP) – the topic of which is substance use treatment initiation. The cross-departmental PIP team is focused on a multi-pronged telehealth-related intervention. Targeted communications about telehealth continue to be dispersed via provider banners and newsletter articles. DVHA's Quality Improvement Administrator prepared and submitted the annual PIP Summary report to the EQRO during the QE0919. DVHA received a score of 100%, demonstrating a solid study design and statistically significant improvement in study measure results from CY 2017 – CY 2018.

Interim indicator data on telehealth use is also being collected to monitor progress. Data points include: # of telehealth episodes of care, # of unduplicated providers billing for telehealth and # of unduplicated members receiving telehealth services. There was an increase in all metrics from the baseline of Q2 SFY 2018. The Quality Unit is also starting to sort these episodes of care by HEDIS diagnosis code value sets for mental health and substance use disorder. Data continues to show that SUD treatment providers are using telehealth in comparatively small numbers and continued focus here could be meaningful.

To that end, Quality staff joined a state-wide stakeholder group lead by the Vermont Program for Quality in Health Care (VPQHC) during QE0919. The purpose of this group is to explore the expansion of telemedicine across the state, including the provision of technical assistance with telehealth platform implementation.

Other Collaborative Quality Improvement Projects

The Quality Unit continues to lead an informal PIPon the topic of chlamydia screening. This topic was one selected after annual review of program performance by the MCE Quality Committee, a clinical sub-committee and the Clinical Utilization Review Board (CURB).

During the most recent quarter the chlamydia project team followed a modified learning collaborative through the Blueprint's Women's Health Initiative. The collaborative includes 8 monthly webinars, running from April-November 2019. Five (5) practices are participating.

Quality Measure Reporting

- CMS' Adult and Child Quality Measure Core Sets – The Quality Unit is working with DVHA's Deputy Commissioner on a larger vision for quality measure production that will enable DVHA to reach full reporting capacity on these measure sets by the year 2024. During QE0919 the Quality Unit continued to explore ways to maximizes the use of available resources, including the potential use of the Vermont's Health Information Exchange (VHIE).. Also during the most recent quarter, the Quality unit staff began preparing the data spreadsheet that supports DVHA's annual CMS Quality Core set reporting through MacPro.
- Healthcare Effectiveness Data & Information Set (HEDIS) measure production – During QE0919 the Quality Unit worked with the contracted HEDIS vendoron a contract amendment. Per the current contract, DVHA also confirmed for the HEDIS vendor which HEDIS hybrid

measures will be produced during CY 2020. DVHA plans to again use internal clinical staff for record abstraction, while the vendor will be responsible for record retrieval.

- Customer Satisfaction Measures– CAHPS Survey – DVHA's Quality Improvement Administrator works with the vendor, Data Stat, to prepare for the annual adult and child CAHPS experience of care surveys, as well as upload our results to the national CAHPS database. During QE0919 the Quality Committee recommended the addition of two (2) survey questions to the 2019 surveys, focused mental health and medication reconciliation. The Quality Improvement Administrator subsequently worked with the vendor to add those questions to the survey tools. All other annual survey materials were also reviewed and approved during the most recent quarter. Surveys will be distributed during QE1219.

Results Based Accountability (RBA)/Process Improvement

The Quality Unit continues to lead the Results Based Accountability (RBA) scorecard development effort at DVHA. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff received training and has used this tool to create a Global Commitment Core Measure scorecard, Experience of Care scorecard, and other performance budgeting scorecards. Additional scorecards that were actively maintained or newly created during QE0919 include the following: Early and Periodic Screening, Diagnostic and Treatment (EPSDT), DVHA Strategic Priorities, GC/Delivery System Related Investments, Payment Reform Models, and an overall DVHA performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Quality Unit staff are also actively engaged in the Agency's Improvement Network. This is a group of staff trained in process improvement, facilitation and tools that can be deployed to help on improvement projects around the Agency.

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) continued their review of the Comprehensive Quality Strategy (CQS). Specifically, the group focused on the performance measures contained in the strategy. Measures to support the waiver objectives were reviewed. The need for Blueprint Community Health Team (CHT) and Vermont Chronic Care Initiative (VCCI) enhanced care coordination measures was identified. The aforementioned measures will be identified and added to the CQS during the next quarter. In addition, the use of National performance measures was reviewed. The group identified the use of the Medicaid Adult/Child Core Measure Sets as well as the measures associated with the CAHPS survey. The group will continue to discuss this topic and identify all applicable measures in use by the end of the next quarter. Finally, the group reviewed the population-specific performance measures included in the previous version of the CQS. This section includes information on population specific metrics for each population covered by the Medicaid program, including children, individuals with mental illness, non-disabled adults, individuals receiving home and community services (HCBS), and individuals receiving long term services and supports (Choices for Care). The group supported the review of payment model and investment measures as a way to ensure that this section of the CQS is aligned with the work happening across AHS. During the next quarter, the group will finalize their measure discussions, as well as engage in a review of the waiver monitoring structure and processes and improvement activities.

Global Commitment (GC) and Delivery System Reform (DSR) Investment Review

AHS Departments are required to monitor and evaluate the performance of their GC and DSR investments on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of GC and DSR investment performance information contained in a web browser-based software application (Clear Impact Scorecard).

During this most recent quarter, VDH and DAIL highlighted the performance of their investments. The Clear Impact Scorecards for the VDH and DAIL investments are included in this report as Attachment 7a and Attachment 7b.

Payment Models & Performance Monitoring

During this quarter, the AHS QIM reviewed the CMS quality criteria and framework sections of the CIS preprint associated with DCF's ongoing payment model. Edits were suggested to ensure that the payment arrangement advances at least one of the goals/objectives of the Comprehensive Quality Strategy (CQS) and that there was a corresponding evaluation plan which measures the degree to which the payment arrangement advanced the CQS goals/objectives.

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of payment model performance information contained in a web browser-based software application (Clear Impact Scorecard).

During this most recent quarter, DVHA highlighted the performance of its Blueprint for Health payment model through three (3) initiatives: Community Health Teams, Patient Centered Medical Homes and the Women's Health Initiative. The Clear Impact Scorecards for this payment model are included in this report as Attachment 8.

Comprehensive Quality Strategy (CQS)/State Transition Plan (STP)

During this quarter, the State learned that it will be unable to meet the original STP submission (Milestone 7.0) due date of October 17, 2019. The inadvertent loss of provider self-assessment & member validation surveys and their associated data resulted in rework that not only impacts the ability to complete the STP submission milestone by the originally anticipated due date – but it also impacts the ability to meet due dates for Milestones 5.0, 5.1, 6.0, as well as, 19.0 (public notice) and 20.0 (STP submission). This incident is not expected to impact the State's ability to complete any of the subsequent milestones in a timely fashion. Given this undesirable occurrence, the State requested an extension to complete the activities associated with the aforementioned STP milestones.

The State's survey vendor, SurveyGizmo, inadvertently deleted/disabled our account – which ultimately resulted in the loss of all five (5) program surveys and their corresponding responses to date. Since learning of this occurrence, the state has been working with the vendor to better understand the reason for this action and to attempt to recover/restore the missing surveys and data. The STP Implementation Team has also conducted a gap analysis to determine the impact of this action on

progress to date, brainstorm solutions, and determine the most effective and efficient way to recreate the surveys and/or collect/recollect any of the missing data. The inability to automatically restore the missing surveys and their corresponding data - along with the missing data being more extensive/involved than initially anticipated (i.e., member assisted surveys) – necessitated a request to CMS to extend the due date for a number of the STP milestones by approximately 6 months. In addition, a status change request (i.e., delay) was entered into the HCBS STP site for the impacted milestones (i.e., 6 months form original due date). The STP implementation team will continue to restore the lost data during the next two quarters.

IX. Demonstration Evaluation

During this quarter, the AHS Quality Improvement Manager continued to work with the independent auditor, PHPG, to advance the waiver evaluation activities. Specific activities for the broader wavier evaluation included the submission and review of evaluation measures from the various AHS programs. During the next quarter, the evaluation team will review changes to the evaluation requirements and determine necessary adjustments to current data collection/submission processes to accommodate these changes. Also, during this quarter, the AHS QIM worked with PHPG to finalize provider surveys to address the SUD evaluation requirements. The surveys were piloted and then sent to all appropriate SUD providers. Data collection will continue through the next quarter.

X. Compliance

Key updates from QE0919:

- EQRO Annual Audit
- Compliance Committee
- Electronic Visit Verification
- Intra-Governmental Agreement (IGA) between AHS and DVHA
- SUD Monitoring Protocol & Metrics Workbook

EQRO

During this quarter, the EQRO, HSAG, performed a desk review of documents and an on-site review that included reviewing additional documents and conducting interviews with key staff members. These annual audits follow a three-year cycle of standards. HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in seven performance categories (i.e., standards). The seven standards included requirements associated with the federal Medicaid managed care access standards found at CFR §438.206–438.210 and the enrollment and disenrollment requirements (§438.54–§438.56), which are part of the Centers for Medicare & Medicaid Services (CMS) Structure and Operations standards. The standards included requirements related to the following:

- Availability of Services;
- Furnishing of Services;
- Cultural Competence;

- Coordination and Continuity of Care;
- Coverage and Authorization of Services;
- Emergency and Poststabilization Services; and
- Disenrollment Requirements

Subject matter experts and managers from several units and departments represented their programs and provided answers and documents to the reviewers. During the review, the auditors discussed some strengths and potential required corrective actions as well as some recommendations to make our programs stronger. During the onsite review exit interview, we learned that there would be required actions for this audit. Upon completion of the audit, DVHA and AHS staff discussed strategies for better document control and methods for following up on previously corrected items. An analysis of the final audit report will be provided in next quarter's report.

Also, during this quarter, the EQRO visited Vermont to conduct Performance Measure Validation (PMV) activities. The validation activities were conducted as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.* Information was collected using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities are described as follows: opening session, claims and encounter data system, membership and enrollment data system and processes, provider data, data integration/reporting and primary source verification, closing summation conference and next steps. A report documenting the result of the PMV activities is due next quarter.

EQRO Performance Improvement Project Validation activities are described in the Quality Improvement Section of this report.

Compliance Committee

DVHA and AHS staff have been discussing strategies for better aligning the compliance needs of our agency. We are developing improved methods for ensuring coordination and accountability across our system and expect to formalize these new structures next quarter.

Electronic Visit Verification

In response to section 12006 of the 21st Century Cures Act, Vermont is implementing an electronic visit verification system (EVV) to electronically verify personal care service visits in home and community settings. Since the last report, the following milestones for this project were met this quarter:

- Project staff completed a list of business requirements for this project.
- Project staff began work with vendors to create software interfaces to link EVV data from Home Health Agencies with the data aggregator. This work will allow DVHA to analyze multiple data sources in one single database, which will be connected to our Medicaid Management and Information System.
- A formal outreach plan is being used to communicate project milestones and details to internal and external stakeholders. This work includes mailings to beneficiaries and providers in our self-directed programs. A slide presentation is under development for delivery to advisory boards and stakeholder groups next quarter.

- Project staff completed several workflows designed to address interoperability between applications and procedures used to deliver personal care services.
- DVHA submitted a request to extend the implementation deadline for EVV compliance from 1/1/20 to 1/1/21. A response from CMS is anticipated early next quarter.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, the AHS QIM received feedback from CMS on the 2019 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA. The feedback was reviewed internally, responses were developed, and an updated version of the IGA was submitted to CMS. Approval of the 2019 IGA was received by the end of the quarter. All requested changes to the 2019 agreement were incorporated into the 2020 version and sent to CMS for review/approval. CMS feedback on the 2020 IGA is anticipated during the next quarter.

SUD Monitoring Protocol & Metrics Workbook

During this quarter, CMS approved Vermont's SUD Monitoring Protocol and its associated Metrics Workbook. The SUD monitoring protocol was approved for September 17, 2019 through December 31, 2021. The waiver Special Terms and Conditions were amended to incorporate the documents (Attachment O). Per 42 CFR 43 1.424(c), the approved SUD monitoring protocol was posted to Vermont's Medicaid website.

XI. Reported Purposes for Capitated Revenue Expenditures

Provided that DVHA's contractual obligation to the populations covered under the Demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this Demonstration may be used for the following purposes:

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches and other innovative programs to improve the health outcomes, health status and the quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

Attachment 6 is a summary of Investments, with applicable category identified, for QE0919.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook
Attachment 2: Enrollment and Expenditures Report
Attachment 3: Complaints Received by Health Access Member Services
Attachment 4: Medicaid Grievance and Appeal Reports
Attachment 5: Office of the Health Care Advocate Report
Attachment 6: QE0919 Investments

Attachment 7a: Investment Scorecard: Vermont Department of Health
Attachment 7b: Investment Scorecard: Department of Disabilities, Aging, and Independent Living
Attachment 8: Payment Model Scorecard: Blueprint for Health (3)

XIII. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-505-0285 (P)
	280 State Drive	802-241-0450 (F)
	Waterbury, VT 05671-1000	sarah.clark@vermont.gov
Policy/Program:	Ashley Berliner, Director of Health Care Policy & Planning	
	VT Agency of Human Services	802-578-9305 (P)
	280 State Drive, Center Building	802-241-0958 (F)
	Waterbury, VT 05671-1000	ashley.berliner@vermont.gov
Managed Care Entity:	Cory Gustafson, Commissioner	
	Department of VT Health Access	802-241-0147 (P)
	280 State Drive, NOB 1 South	802-879-5962 (F)
	Waterbury, VT 05671-1010	cory.gustafson@vermont.gov

Date Submitted to CMS: November 15, 2019

ATTACHMENTS

Attachment 1 - Budget Neutrality

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
Oct 31, 2019

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,991,043	$ 130,175,297	$ 99,691,296	$ -	$ -	$ 372,857,636
ABD - Non-Medicare - Child	$ 84,336,025	$ 77,494,218	$ 58,119,791	$ -	$ -	$ 219,950,034
ABD - Dual	$ 664,763,975	$ 694,159,136	$ 538,364,060	$ -	$ -	$ 1,897,287,171
ANFC - Non-Medicare - Adult	$ 101,852,028	$ 96,977,931	$ 56,648,697	$ -	$ -	$ 255,478,656
ANFC - Non-Medicare - Child	$ 393,030,660	$ 406,821,769	$ 311,553,672	$ -	$ -	$ 1,111,406,101
Total Expenditures Without Waiver	**$ 1,386,973,732**	**$ 1,405,628,349**	**$ 1,064,377,517**	**$ -**	**$ -**	**$ 3,856,979,597**
With Waiver						
ABD Non Medicare Adult	$ 162,602,154	$ 162,728,372	$ 130,375,180	$ -	$ -	$ 455,705,705
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 45,585,817	$ -	$ -	$ 172,256,039
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 364,652,615	$ -	$ -	$ 1,272,240,020
ANFC - Non-Medicare - Adult	$ 84,040,228	$ 83,558,956	$ 51,625,469	$ -	$ -	$ 219,224,653
ANFC - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 266,124,893	$ -	$ -	$ 907,375,059
Premium Offsets	$ (655,991)	$ (772,935)	$ (570,272)	$ -	$ -	$ (1,999,197)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,037,174	$ -	$ -	$ 3,904,497
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 4,547,783	$ -	$ -	$ 17,145,786
VT Global Rx	$ 13,824,166	$ 15,300,919	$ 7,745,382	$ -	$ -	$ 36,870,467
VT Global Expansion VHAP	$ 414,824	$ 716,198	$ 945,092	$ -	$ -	$ 2,076,115
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,296,285	$ -	$ -	$ 25,868,844
Investments	$ 142,332,671	$ 148,500,000	$ 83,413,062	$ -	$ -	$ 374,245,734
Total Expenditures With Waiver	**$ 1,238,718,223**	**$ 1,284,417,019**	**$ 961,778,480**	**$ -**	**$ -**	**$ 3,484,913,721**
Supplemental Test: New Adult (Gross)						
Limit New Adult	$ 370,689,611	$ 375,735,053	$ 279,001,184	$ -	$ -	$ 1,025,425,848
Without Waiver SUD - IMD New Adult Expenditures		$ 2,704,249	$ 3,694,435	$ -	$ -	$ 6,398,684
With Waiver New Adult Expenditures	$ 295,620,340	$ 312,104,578	$ 247,787,110	$ -	$ -	$ 855,512,027
With Waiver SUD - IMD New Adult Expenditures		$ 2,826,119	$ 4,345,428	$ -	$ -	$ 7,171,547
Surplus (Deficit)	*$ 75,069,271*	*$ 63,508,605*	*$ 30,563,082*	*$ -*	*$ -*	$ 169,140,958
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 383,750	$ -	$ -	$ 651,789
SUD - IMD ABD - Dual		$ 214,495	$ 330,334	$ -	$ -	$ 544,829
SUD - IMD ANFC - Non-Medicare - Adult		$ 533,391	$ 484,901	$ -	$ -	$ 1,018,293
Limit SUD IMD Without Waiver		**$ 1,015,926**	**$ 1,198,985**	**$ -**	**$ -**	**$ 2,214,911**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 454,283	$ -	$ -	$ 704,103
SUD - IMD ABD - Dual		$ 199,224	$ 389,433	$ -	$ -	$ 588,657
SUD - IMD ANFC - Non-Medicare - Adult		$ 540,841	$ 588,876	$ -	$ -	$ 1,129,718
Limit SUD IMD With Waiver		**$ 989,886**	**$ 1,432,592**	**$ -**	**$ -**	**$ 2,422,478**
Surplus (Deficit)		*$ 26,040*	*$ (233,607)*	*$ -*	*$ -*	$ (207,567)
Waiver Savings Summary						
Annual Savings	$ 148,255,509	$ 121,211,330	$ 102,599,037	$ -	$ -	$ 372,065,876
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,476,653	$ 30,302,833	$ 25,649,759	$ -	$ -	$ 100,429,244
Total Savings	$ 44,476,653	$ 30,302,833	$ 25,649,759	$ -	$ -	$ 100,429,244
Cumulative Savings	***$ 44,476,653***	***$ 74,779,485***	***$ 100,429,244***	***$ 100,429,244***	***$ 100,429,244***	***$ 100,429,244***
	11%	9%	10%			

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2019 Investments tab
See EG MM CY 2019 Tab for Member Month Reporting

Budget Neutrality New Adult

New Adult (w/ and w/o Child) Medical Costs Only	**DY 12 – PMPM**				**DY 13 – PMPM**				**DY 14 – PMPM**			
	QE 0317	**QE 0617**	**QE 0917**	**QE 1217**	**QE 0318**	**QE 0618**	**QE 0918**	**QE 1218**	**QE 0319**	**QE 0619**	**QE 0919**	**QE 1219**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26	$540.03	$540.03	$540.03	$540.03	$562.71	$562.71	$562.71	
(B-1) eligible member months w/ Child	55,223	57,077	56,789	55,632	55,583	55,408	55,889	57,002	57,954	58,480	58,408	
(B-2) eligible member months w/o Child	124,999	124,981	121,338	119,219	120,870	119,755	116,895	114,365	110,732	106,925	103,318	
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,619,871.98	$ 29,580,726.02	$ 29,431,467.14	$ 28,831,840.32	$ 30,016,487.49	$ 29,921,982.24	$ 30,181,736.67	$ 30,782,790.06	$ 32,611,295.34	$ 32,907,280.80	$ 32,866,765.68	
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,781,981.74	$ 64,772,653.06	$ 62,884,631.88	$ 61,786,438.94	$ 65,273,426.10	$ 64,671,292.65	$ 63,126,806.85	$ 61,760,530.95	$ 62,310,003.72	$ 60,167,766.75	$ 58,138,071.78	
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%	53.47%	53.89%	53.89%	53.89%	53.89%	
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%	89.95%	89.99%	93.00%	93.00%	93.00%	
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,586,382.28	$ 16,109,663.39	$ 16,028,377.00	$ 15,416,385.02	$ 16,049,815.86	$ 15,999,283.90	$ 16,138,174.60	$ 16,588,845.56	$ 17,574,227.06	$ 17,733,733.62	$ 17,711,900.02	
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,289,063.93	$ 56,280,958.24	$ 54,640,456.64	$ 53,562,663.92	$ 58,713,446.78	$ 58,171,827.74	$ 56,782,562.76	$ 55,578,301.80	$ 57,948,303.46	$ 55,956,023.08	$ 54,068,406.76	
Subtotal Federal Share Supplemental Cap 1	$ 71,875,446.21	$ 72,390,621.63	$ 70,668,833.64	$ 68,979,048.94	$ 74,763,262.64	$ 74,171,111.64	$ 72,920,737.36	$ 72,167,147.37	$ 75,522,530.52	$ 73,689,756.70	$ 71,780,306.78	
Total FFP reported for New Adult Group	$ 62,816,665.28	$ 61,830,391.33	$ 54,643,069.28	$ 51,158,852.52	$ 62,183,045.44	$ 63,756,150.76	$ 62,666,336.47	$ 61,269,677.13	$ 67,854,834.87	$ 68,588,592.26	$ 63,203,442.61	
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 9,058,780.94	$ 10,560,230.30	$ 16,025,764.37	$ 17,820,196.41	$ 12,580,217.20	$ 10,414,960.88	$ 10,254,400.88	$ 10,897,470.24	$ 7,667,695.65	$ 5,101,164.44	$ 8,576,864.17	

Report to
The Vermont Legislature

Medicaid Program Enrollment and Expenditures Quarterly Report

In Accordance with 33 V.S.A. § 1901f

Submitted to: The General Assembly

Submitted by: Martha Maksym, Acting Secretary
Agency of Human Services

Prepared by: Cory Gustafson, Commissioner
Department of Vermont Health Access

Report Date: September 1st, 2019

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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BACKGROUND

In accordance with 33 V.S.A. § 1901f, a quarterly report on enrollment and total expenditures by Medicaid eligibility group for all programs paid for by the Department of Vermont Health Access shall be submitted to the General Assembly by March 1, June 1, September 1, and December 1 of each year. To the extent such information is available, total expenditures for Medicaid-related programs paid for by other departments within the Agency of Human Services shall be included.

KEY TERMS

Caseload: Average monthly member enrollment

PMPM: Per Member Per Month

MEG: Medicaid Eligibility Group

ABD Adult: Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy

ABD Dual: Beneficiaries eligible for both Medicare and Medicaid; categorized as aged, blind, disabled, and/or medically needy

General Adult: Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance

New Adult Childless: Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who do not have dependent children

New Adult w/Child: Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who have dependent children

BD Child: Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy

General Child: Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

Underinsured Child: Beneficiaries under age 19 with household income 237-312% FPL with other (primary) insurance

CHIP: Children's Health Insurance Program; Beneficiaries under age 19 with household income 237-312% FPL with no other insurance

Sunsetted Programs: Expenditures still being incurred for programs no longer active such as VHAP, VHAP ESI, and Catamount.

Vermont Premium Assistance: Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Vermont Cost Sharing: Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Pharmacy Only: Assistance to help pay for prescription medicines based on income, disability status, and age

Choices for Care (Traditional): Vermont's Long-Term Care Medicaid Program for Vermonters in nursing homes, home-based settings, and/or enhanced residential care (ERC)

Choices for Care (Acute): Long-Term Care Medicaid for Vermonters who would otherwise qualify for Choices for Care (Traditional), but who are currently receiving a lower level of care

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

The Department of Vermont Health Access

Caseload and Expenditure Report
All AHS and AOE YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA Caseload	SFY'19 BAA Budget	SFY'19 BAA PMPM	SFY'19 Actuals Thru June 30, 2019 Caseload	SFY'19 Actuals Thru June 30, 2019 Expenses	SFY'19 Actuals Thru June 30, 2019 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,250	$ 146,702,165	$ 1,956.03	6,485	$ 142,431,661	$ 1,830.29	97.09%
ABD Dual	17,742	$ 242,706,736	$ 1,139.98	17,651	$ 222,162,634	$ 1,048.87	91.54%
General Adult	12,958	$ 88,656,569	$ 570.15	10,148	$ 75,482,342	$ 619.85	85.14%
New Adult Childless	39,248	$ 227,769,694	$ 483.61	37,432	$ 231,699,072	$ 515.82	101.73%
New Adult w/Child	18,813	$ 87,998,161	$ 389.79	19,101	$ 96,846,003	$ 422.52	110.05%
BD Child	2,166	$ 64,844,308	$ 2,494.78	2,093	$ 59,244,041	$ 2,358.91	91.36%
General Child	59,811	$ 332,852,007	$ 463.76	58,779	$ 341,824,722	$ 484.62	102.70%
Underinsured Child	584	$ 1,469,272	$ 209.66	563	$ 1,380,553	$ 204.22	93.96%
CHIP	4,697	$ 12,551,135	$ 222.68	4,479	$ 13,130,395	$ 244.30	104.62%
Sunsetted Programs	-	$ -		-	$ 1,118,192		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,119	$ 5,941,367	$ 28.92	89.83%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	4,897	$ 1,482,370	$ 25.23	97.50%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,382	$ 9,561,402	$ 76.75	84.77%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,275	$ 206,971,637	$ 4,034.22	98.99%
Choices for Care - Acute	4,390	$ 31,288,498	$ 593.94	4,275	$ 33,949,184	$ 661.73	108.50%
Total Medicaid	196,241	$ 1,465,326,521	$ 622.25	188,507	$ 1,443,225,576	$ 638.01	98.49%

The Department of Vermont Health Access

Caseload and Expenditure Report

All AHS YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA Caseload	SFY'19 BAA Budget	SFY'19 BAA PMPM	SFY'19 Actuals Thru June 30, 2019 Caseload	SFY'19 Actuals Thru June 30, 2019 Expenses	SFY'19 Actuals Thru June 30, 2019 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,250	$ 146,644,178	$ 1,955.26	6,485	$ 141,024,919	$ 1,812.22	96.17%
ABD Dual	17,742	$ 245,148,578	$ 1,151.45	17,651	$ 222,008,459	$ 1,048.14	90.56%
General Adult	12,958	$ 88,621,911	$ 569.93	10,148	$ 75,218,250	$ 617.68	84.88%
New Adult Childless	39,248	$ 228,050,283	$ 484.21	37,432	$ 231,604,027	$ 515.61	101.56%
New Adult w/Child	18,813	$ 88,060,301	$ 390.07	19,101	$ 96,843,563	$ 422.51	109.97%
BD Child	2,166	$ 49,597,023	$ 1,908.16	2,093	$ 45,254,462	$ 1,801.89	91.24%
General Child	59,811	$ 296,053,250	$ 412.48	58,779	$ 304,164,230	$ 431.23	102.74%
Underinsured Child	584	$ 1,078,976	$ 153.96	563	$ 1,077,466	$ 159.39	99.86%
CHIP	4,697	$ 10,740,115	$ 190.55	4,479	$ 11,396,184	$ 212.03	106.11%
Sunsetted Programs	-	$ -		-	$ 1,118,192		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,119	$ 5,941,367	$ 28.92	89.83%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	4,897	$ 1,482,370	$ 25.23	97.50%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,382	$ 9,561,402	$ 76.75	84.77%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,275	$ 206,971,637	$ 4,034.22	98.99%
Choices for Care - Acute	4,390	$ 32,083,931	$ 609.03	4,275	$ 33,949,184	$ 661.73	105.81%
Total Medicaid	196,241	$ 1,414,566,521	$ 600.69	188,507	$ 1,387,615,713	$ 613.42	98.09%

The Department of Vermont Health Access

Caseload and Expenditure Report

DVHA Only YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA Caseload	SFY'19 BAA Budget	SFY'19 BAA PMPM	SFY'19 Actuals Thru June 30, 2019 Caseload	SFY'19 Actuals Thru June 30, 2019 Expenses	SFY'19 Actuals Thru June 30, 2019 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,250	$ 57,191,818	$ 762.56	6,485	$ 61,197,266	$ 786.41	107.00%
ABD Dual	17,742	$ 57,507,834	$ 270.11	17,651	$ 58,079,913	$ 274.21	100.99%
General Adult	12,958	$ 75,554,021	$ 485.89	10,148	$ 62,828,505	$ 515.94	83.16%
New Adult Childless	39,248	$ 202,267,933	$ 429.47	37,432	$ 204,022,529	$ 454.21	100.87%
New Adult w/Child	18,813	$ 81,007,952	$ 358.83	19,101	$ 88,370,003	$ 385.54	109.09%
BD Child	2,166	$ 20,395,140	$ 784.67	2,093	$ 21,234,113	$ 845.48	104.11%
General Child	59,811	$ 155,918,142	$ 217.24	58,779	$ 165,815,234	$ 235.08	106.35%
Underinsured Child	584	$ 502,278	$ 71.67	563	$ 472,464	$ 69.89	94.06%
CHIP	4,697	$ 8,362,970	$ 148.37	4,479	$ 9,234,963	$ 171.82	110.43%
Sunsetted Programs	-	$ -		-	$ 1,118,192		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,119	$ 5,941,367	$ 28.92	89.83%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	4,897	$ 1,482,370	$ 25.23	97.50%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,382	$ 9,561,402	$ 76.75	84.77%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,275	$ 206,971,637	$ 4,034.22	98.99%
Choices for Care - Acute	4,390	$ 28,306,765	$ 537.33	4,275	$ 31,156,672	$ 607.30	110.07%
Total Medicaid	196,241	$ 915,502,828	$ 388.77	188,507	$ 927,486,630	$ 410.01	101.31%

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
dvha.vermont.gov

Questions, Complaints and Concerns Received by Health Access Member Services
July 1, 2019 – September 30, 2019

The following information represents the weekly documentation of Green Mountain Care Member Questions, Complaints, and Concerns as reported to Green Mountain Care Member Services (1-800-250-8427) per quarter. Calls are addressed per guidelines (policy, scripts, multi-tier resolver groups) developed by the Department of Vermont Health Access and in collaboration with Maximus. The nature of each call is assessed by the customer service representative (CSR) and the appropriate action (appeal rights, fair hearings, policy explanation, etc.) is then applied. If the call requires an action or advice that is beyond the scope of information available to the CSR, the member is then afforded a warm transfer to the appropriate subject matter expert within DVHA (e.g. Provider and Member Relations, Health Access Eligibility & Enrollment Unit, etc.). Each documented question, complaint, or concern is captured in order to ensure that the member's needs are met and that proper resolution is guaranteed.

July 2019

- Caller wanted to submit negative feedback about VTMedicaid.com website for finding providers. Caller states that all the doctor's he's looked at for Morrisville and Copley hospital are not accepting patients, but the website says they are. Also, he feels that the Medicaid Handbook he received is not explicit enough and doesn't explain enough about his benefits. CSR apologized for his frustrations, offered to assist him in finding a provider, and explained that if there is a service not listed in his handbook, his provider could contact provider services. Offered to document his feedback.

August 2019

- Caller wanted to submit negative feedback about the provider look up website. Caller is trying to find a pediatric psychologist in the Norwich area. There are providers in the area but they will not take Medicaid. Caller is unable to get any that she has contacted to take Medicaid. Additionally, she wanted it noted that the vtmedicaid.com provider portal does not have a listing for psychologists at all even though it is a covered service. The search does not account for anything other than town names, not counties or nearness to a certain zip code. Even under psychiatrists there are none in the area. Caller feels there should be other ways to search when using this website. CSR apologized for her frustration and offered to assist her in using the website. Also offered to document her feedback.
- Caller wanted to submit negative feedback about her Vpharm coverage. Caller feels that it was not assisting her and her husband during the months she had it. She feels that she was being charged $40 for nothing. She was displeased with the coverage they received as it didn't assist beyond what their PDP was covering. She also feels we were taking her

money and not providing any real assistance with her RX. CSR apologized for her frustration with the programs, went over the benefits of the program and offered to document her feedback.

September 2019

- Caller wanted to submit feedback about being enrolled with a PCP eff 10/1. Appears he was auto-enrolled w/his PCP yesterday (9.5.19) w/a 10.1.19 effective date (per PCP enrollment protocol). Caller states that he should have been told about his being on fee for service (FFS) Medicaid before PCP enrollment takes effect and that we should have information about that type of coverage on the website and/or our references to give to people. He states he was given different information about coverage by different CSRs. He feels he should have been advised that he was active on FFS Medicaid and that it means he doesn't need to get referral to specialist from his PCP--feels it would have saved him a lot of time thinking he needs to find PCP immediately for Rx needs, since it needs to be prescribed by specialist. He states that he would like the staff to be more educated on FFS Medicaid, how to identify it, and what that coverage means to the patient. He was provided info based on someone enrolled in managed care, which will only be valid advice after his PC+ enrollment takes effect on 10.1.19. CSR apologized and went over the process with the customer and then a supervisor took over the call and offered to document his feedback.
- Caller wanted to submit negative feedback about the DME that is covered through Medicaid. He states he needs plastic back diapers because the diapers that Medicaid supplies do not work for him. He wants Medicaid to supply different diapers that hold more waste and are plastic instead of paper. CSR apologized for his frustration and offered to document his feedback.
    - *PMR will discuss details with DME staff in COU and provide follow up.*
- Caller wanted to submit negative feedback about our limited list of covered services. She states she received a letter about a covered service (didn't divulge much information about it) and wanted to know what specific services are covered. She feels we should have more information on this and not just general information. She also feels it's a waste of time to call her provider to get more in depth information. CSR apologized for her frustration, explained that we only have limited information on covered services and for something specific she would want to talk to her doctor who has access to call provider services. Also, offered to document her feedback.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
July 1, 2019 – September 30, 2019

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on October 16, 2019 from the centralized database that were filed from July 1, 2019 through September 30, 2019.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the Medicaid Managed Care Model.

During this quarter, there were 27 grievances filed; twelve were addressed and one was withdrawn during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 85% were filed by the beneficiary, 11% were filed by the beneficiary's representative and 4% were filed by another source. Of the 27 grievances filed, DMH had 93% and DAIL had 7%. There were no grievances filed for DVHA, VDH or DCF during this quarter.

Grievances were filed for service categories case management, counseling services, and mental health services.

There were no Grievance Reviews filed this quarter.

Appeals: Health Care Administrative Rule 8.100 defines adverse benefit determinations that the Managed Care Model makes that are subject to an internal appeal. These actions are:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the Managed Care provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

During this quarter, there were 21 appeals filed. Of these 21 appeals, 10 were resolved (48%), 9 were still pending (43%), 1 was filed too late (5%) and 1 was withdrawn (5%).

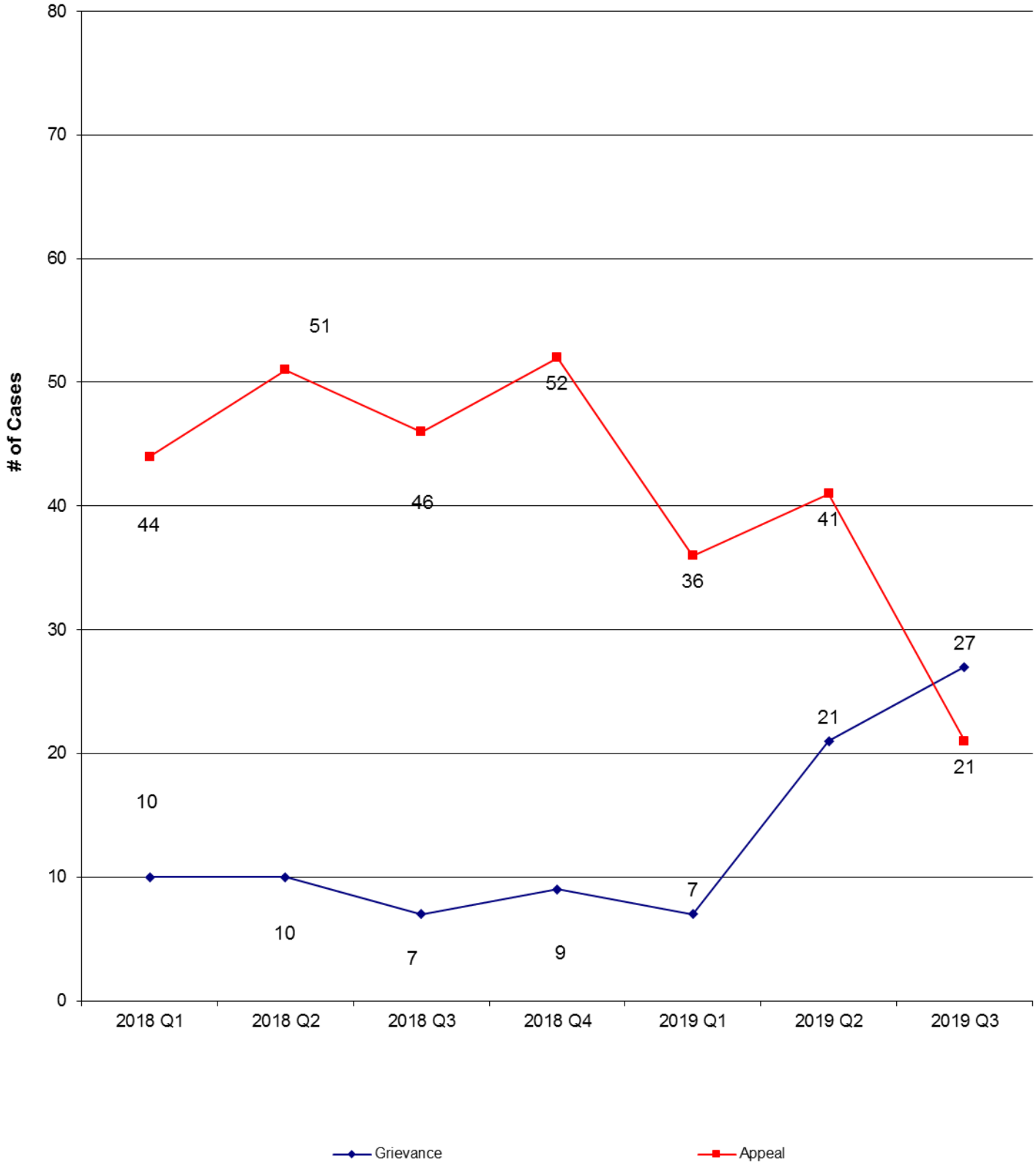
Of the 10 appeals that were resolved this quarter, 80% were resolved within the statutory time frame of 30 days. Two appeal were resolved after the 30-day timeframe, one of these appeals was extended at the request of the beneficiary. The average number of days it took to resolve these cases was 22 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

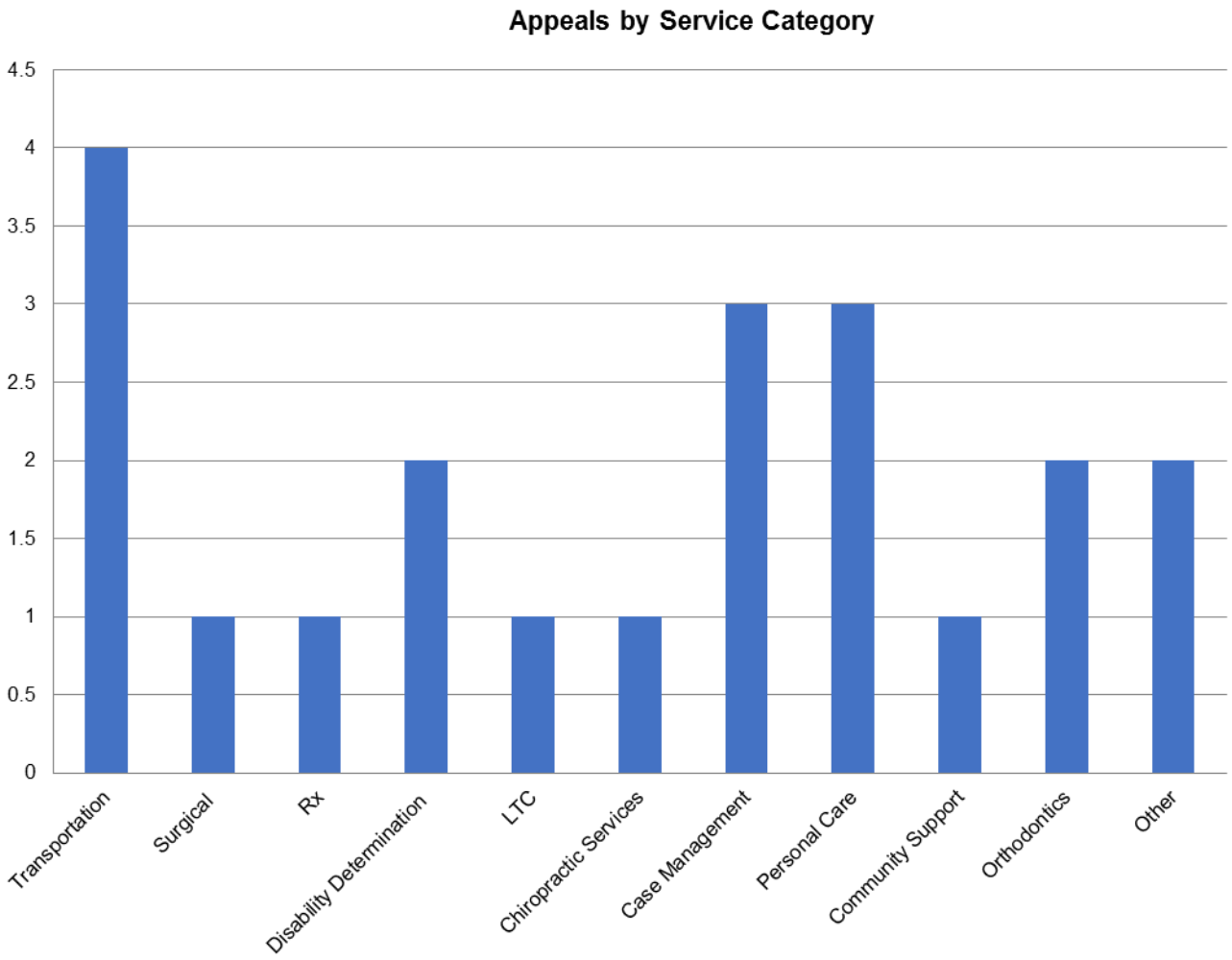
Of the 21 appeals filed, DVHA had 9 appeals filed (43%), DAIL had 9 (39%), VDH had 2 (9%) and DMH had 2(9%).

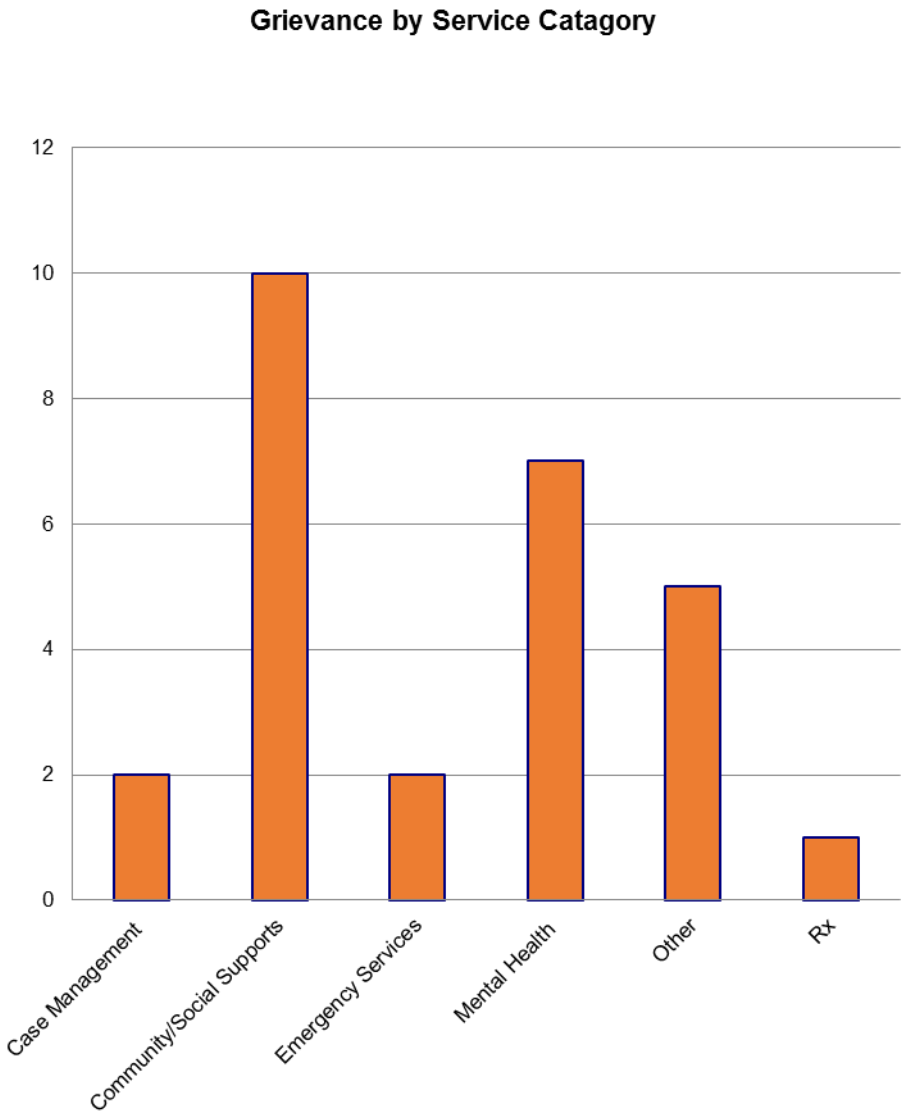
The appeals filed were for service categories; disability determinations, orthodontics, surgical, personal care, chiropractic, transportation, long term care, community supports, prescriptions, community/social supports and case management.

Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing filed this quarter.

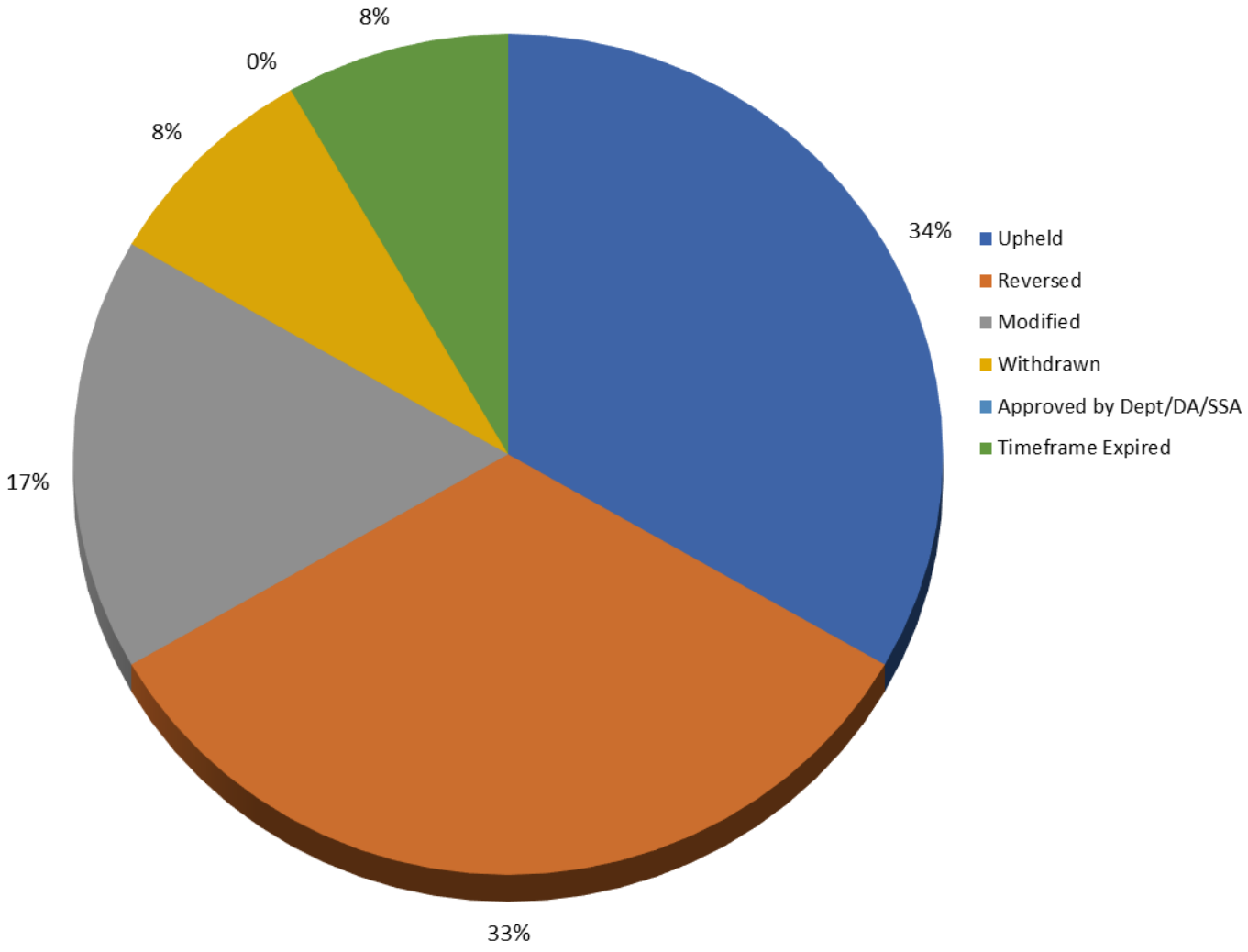
Grievances and Appeals
January 1, 2018– September 30, 2019




Appeals by Service Category
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Transportation
Surgical
Rx
Disability Determination
LTC
Chiropractic Services
Case Management
Personal Care
Community Support
Orthodontics
Other


Grievance by Service Catagory
12
10
8
6
4
2
0
Case Management
Community/Social Supports
Emergency Services
Mental Health
Other
Rx

Appeal Resolutions
7/1/2019 thru 9/30/2019



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

July 1, 2019- September 30, 2019

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

October 18, 2019

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Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters through both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters through individual advocacy and representing the public before the Green Mountain Care Board, state agencies, and the state legislature.

This quarter, the HCA helpline advocates focused on improving access to dental care in Vermont. Advocates attended the work group on improving dental access (*See Priorities*). Every quarter we have Vermonters who have trouble getting the dental care that they need. This quarter, the Dental Services webpage had 788 page views, which was a 92% increase from previous quarters. Our chart on Vermont Dental Clinics was also downloaded 71 times. We had 22 cases with Vermonters facing barriers to accessing dental services. The expansion of the dental benefits for Medicaid beneficiaries will help Vermonters like Joann in the featured story on this page. Even with the expansion of Medicaid dental benefits, many other Vermonters do not have dental insurance or access to adequate dental care, and are forced to forgo obtaining the care, or go into debt getting the recommended care.

The HCA also worked this quarter to make sure that Vermonters are aware that they can apply for patient financial assistance when they have bills from hospital stays. The HCA is working with hospitals to make sure that the patient financial assistance is accessible, and that the applications are written in plain language that consumers can understand.

Joann's Story

Joann was in the middle of a dental emergency. She had an infected tooth that she needed to get extracted. She was uninsured. She had a voucher from Vermont's Economic Services Division (ESD) to help pay for the extraction, but she could not find a provider willing to accept it. ESD will issue general assistance vouchers for emergency treatment to relieve pain, bleeding, or infection. The voucher is not dental insurance and cannot be used for routine care or the extraction of non-infected teeth. It also can be difficult to find providers who will accept the voucher. After talking to Joann, the HCA advocate concluded that Joann was eligible for Medicaid. In 2019, Medicaid provides dental coverage up to $510 per calendar year for beneficiaries age 21 or older. There is no dental cap for pregnant women on Medicaid or individuals under 21. The advocate helped Joann with her Medicaid application—and was able to get the coverage expedited. She also helped her find a provider who accepted Medicaid. Joann was able to make an appointment and get started on her dental work. In 2020, Joann will have increased dental benefits. In 2020, the dental benefit for adults over 21 will be increased to $1,000 per calendar year, and beneficiaries will be able to have two preventive visits per year and not have those services count towards the cap. Now that she is on Medicaid, Joann plans on using the expanded benefits to address her ongoing dental needs.

The HCA represents Vermonters through individual, administrative, and legislative advocacy. Our policy priorities reflect our daily work with Vermonters struggling with a health care system that often does not meet their needs. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Overview

The HCA provides assistance to consumers through our statewide hotline (**1-800-917-7787**) and through the Online Help Request feature on our website, Vermont Law Help (*https://vtlawhelp.org/health)*. We have a team of advocates located in Vermont Legal Aid's Burlington office that provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 933 calls[1] this quarter. We divided these calls into broad categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **27.22%** (254) about **Access to Care**
- **11.04%** (103) about **Billing/Coverage**
- **1.07%** (10) about **Buying Insurance**
- **10.18%** (95) **about Complaints**
- **9.65 %** (90) about **Consumer Education**
- **25.51%** (238) about **Eligibility** for state and federal programs
- **11.90%** (111) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 238 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 388 cases had eligibility listed as a secondary concern.

In each section of this narrative, we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Determining which issue is the "primary" issue is sometimes difficult when there are multiple causes for a caller's problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. See the breakdowns of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the "primary" reason for their call.

The most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

The full quarterly report for July-September 2019, includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities,** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 933 calls (compared to 835 calls last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 309 calls (308 calls last quarter)

[1] The term "call" includes cases we get through the intake system on our website.

- **Commercial Plan Beneficiaries**: 162 calls (171 calls last quarter)
- **Uninsured Vermonters**: 90 calls (64 calls last quarter)
- **Vermont Health Connect (VHC)**: 208 calls (191 calls last quarter)
- **Reportable Activities (Summary & Detail)**: 51 activities and 7 documents (105 activities, 17 documents)

Individual Consumer Assistance

Case Examples

These case summaries illustrate the types of problems we helped Vermonters resolve this quarter:

Ava's Story:

Ava called the HCA when she found out her Vermont Health Connect (VHC) plan had closed. Ava was getting Advance Premium Tax Credit (APTC) to help her pay the monthly premium for the VHC plan. If you receive APTC, you are entitled to a three-month grace period. This means that if you get behind on your premium payments, you have three months to catch up before the plan will terminate. When the HCA advocate investigated, he found that Ava had been in and out of grace periods all year. Ava had not understood that her premium for the current month needed to be postmarked by the last day of the prior month. This meant that she had been paying late. However, the advocate found that VHC had terminated Ava incorrectly. She was only in the second month of her grace period, not the third and final month. This meant that she had one more month to catch up on her premiums before she could be terminated for non-payment. VHC agreed that it had terminated Ava in error and reinstated the coverage.

Rebecca's Story:

Rebecca found out that she was pregnant and did not have any health care coverage. She could not afford her prenatal care without coverage. The HCA advocate first investigated if Rebecca was eligible for Dr. Dynasaur for pregnancy. This type of Medicaid covers pregnant women, but Rebecca's income was slightly over the limit. Because she was pregnant, however, Rebecca was entitled to a special enrollment period (SEP) that would allow her to enroll on a VHC plan outside of the open enrollment period. The pregnancy SEP allows an individual who is not enrolled in VHC to enroll when they become pregnant. The SEP is available at any time after the start of the pregnancy. It also allows family members to enroll with the pregnant person. This meant that both Rebecca and her spouse had a special enrollment period to enroll on a VHC plan. They both enrolled on a VHC plan, and also received Advanced Premium Tax Credit to help pay for their monthly premium, which meant that they would have coverage in place for the upcoming appointments and the birth of their baby.

Deidre's Story:

Deidre was worried that she was going to lose her Advance Premium Tax Credit (APTC) that helped pay for her VHC plan. She had received a letter from her insurance carrier telling her that she needed to enroll in Medicare Part B. Her insurance carrier said that they would not pay claims because she was supposed to be on Part B. Deidre was over 65 years old, but she was not enrolled on any part of Medicare. She was not eligible for free Medicare Part A. Medicare Part A covers hospital stays, and to qualify for free Part A, you (or your spouse) need to have at least 40 calendar quarters of work where you paid Social Security taxes. Deidre had not worked in a job paying Social Security taxes for enough time, so if she wanted to enroll onto Part A, it would cost several hundred dollars per month. Because she was not eligible for free Part A, she could continue to receive APTC for her VHC plan. Normally, when you become Medicare eligible, you are no longer eligible for APTC. But because Deidre fell into

the small group of people who are not eligible for free Part A, she stayed eligible for her VHC plan with APTC. The HCA advocate contacted both VHC and the insurance carrier with documentation showing that Deidre was not eligible for free Medicare Part A, so she did not need to enroll in either Medicare A or B, and she was able to stay on her VHC plan with APTC.

Ryan's Story:

Ryan needed to pick up his prescription—and his Medicaid had closed earlier in the year. He had been paying for coverage on his own, but he could no longer afford it. When the HCA advocate investigated, she found that the coverage had closed because he had not completed his annual review. Each year, Medicaid beneficiaries must review their eligibility to see if they still qualify for Medicaid. Ryan had started the review, and had been asked to submit verification of his income. He believed that he had sent in the requested information, but VHC did not have any record of receiving it. The HCA advocate helped Ryan submit a new Medicaid application and find the necessary information to verify his income. She also asked VHC to expedite Ryan's application, so he could pick up his prescription quickly. In addition, the advocate helped Ryan apply for retroactive Medicaid. You can apply for up to three months of retroactive Medicaid from the month that you are found to be eligible. This meant Ryan's providers could submit claims for those months, and he could get reimbursed for his out-of-pocket costs.

Julian's Story:

Julian called because his Medicare Part D prescription drug plan had closed. Julian had been hospitalized for a significant amount of time and had not been able to pay for the Part D plan while in the hospital. He had not been receiving his mail while in the hospital, and thus was not aware that his Part D plan had closed. He only found out when he went to the pharmacy to pick up a prescription. The HCA advocate helped Julian request a "good cause" reinstatement for his Part D plan. To be eligible for a Part D good cause reinstatement, you must request reinstatement within 60 days of your Part D plan's closure. You must also have an unusual or unexpected situation that prevented you from making your Part D payments. Because Julian had been unexpectedly hospitalized for much of his Part D grace period, he met the criteria for a "good cause" reinstatement. His Part D plan was reinstated, and he was able to fill his prescriptions at the pharmacy.

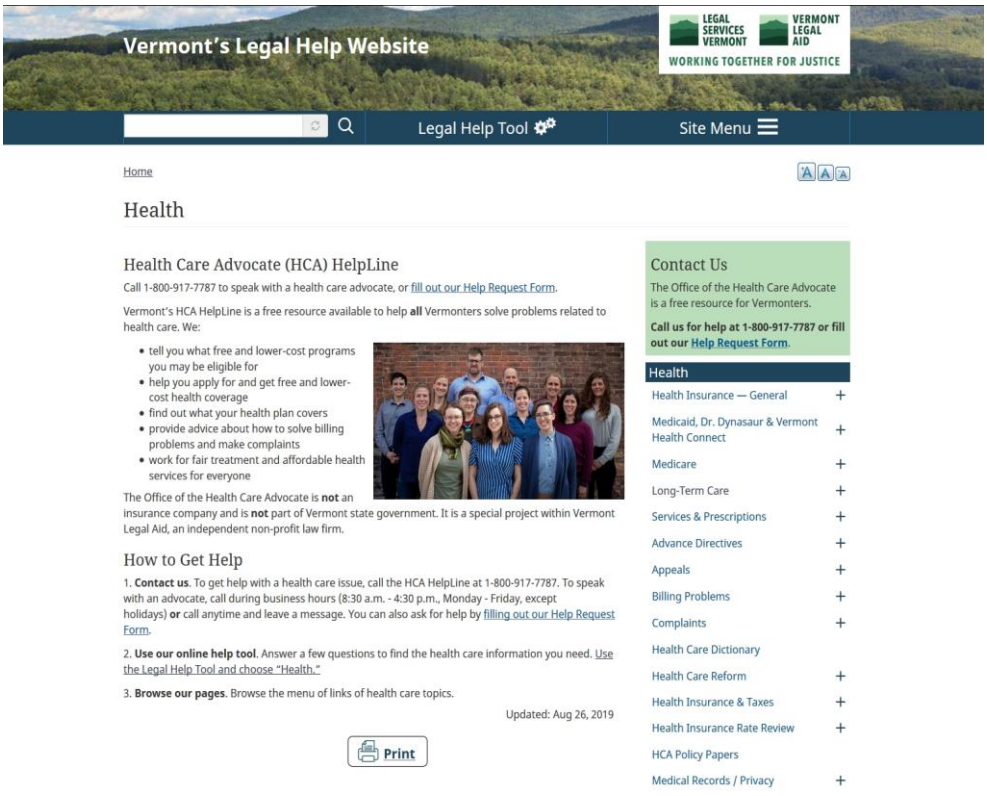
Holden's Story

Holden's son has a chronic medical condition that requires medication. Holden's family had moved out of Vermont for a short while and were now returning. Because Holden adopted his son in Vermont through the foster care system, his son was part of a special group that is eligible for Medicaid until age 21, with no income requirement. Holden's son needed to pick up his prescription, but Holden was having trouble re-enrolling his son into Medicaid. The state was telling him that he needed to provide foster care documentation from another state, which did not make sense because Holden's son was adopted here. The HCA advocate was able to connect Holden with the right person and get his son's Medicaid coverage activated again in Vermont. This meant that Holden was able to pick up the prescription for his son

Priorities

A. The HCA launched an updated and revamped website.

The HCA has an updated and revamped website**.** The VTLawHelp website and its Health pages were updated in July to be easier to navigate, more accessible to people who live with disabilities, and easier to use on mobile devices. The upgraded website will make it easier for Vermonters to find the information that they need. This quarter we saw over 15,000 page views of the Health pages of the website, which was a 31% increase from the same quarter in 2018. We are continually updating and revising the website to ensure it has the most accurate information. We also made it easier for community partners to reach us online. Vermonters can submit requests for help on an updated online form, and they can always call the helpline. *https://vtlawhelp.org/health*



B. The HCA participated in the Dental Access and Medicaid Reimbursement Work Group.

HCA advocates shared the consumer perspective about the challenges of accessing dental care in Vermont for insured, under-insured, and uninsured individuals. The HCA had 22 cases this quarter on access to dental care. We frequently talk to consumers who cannot afford dental care, or cannot find a dentist. Even those who have dental insurance find that there are limits to their coverage. Medicare does not cover routine dental care. The workgroup was charged with reporting back to the state legislature with proposals for improving access to dental care for Vermonters and expanding the number of dentists in the state who accept Medicaid.

C. Overall HCA call volume increased by 12%, this quarter.

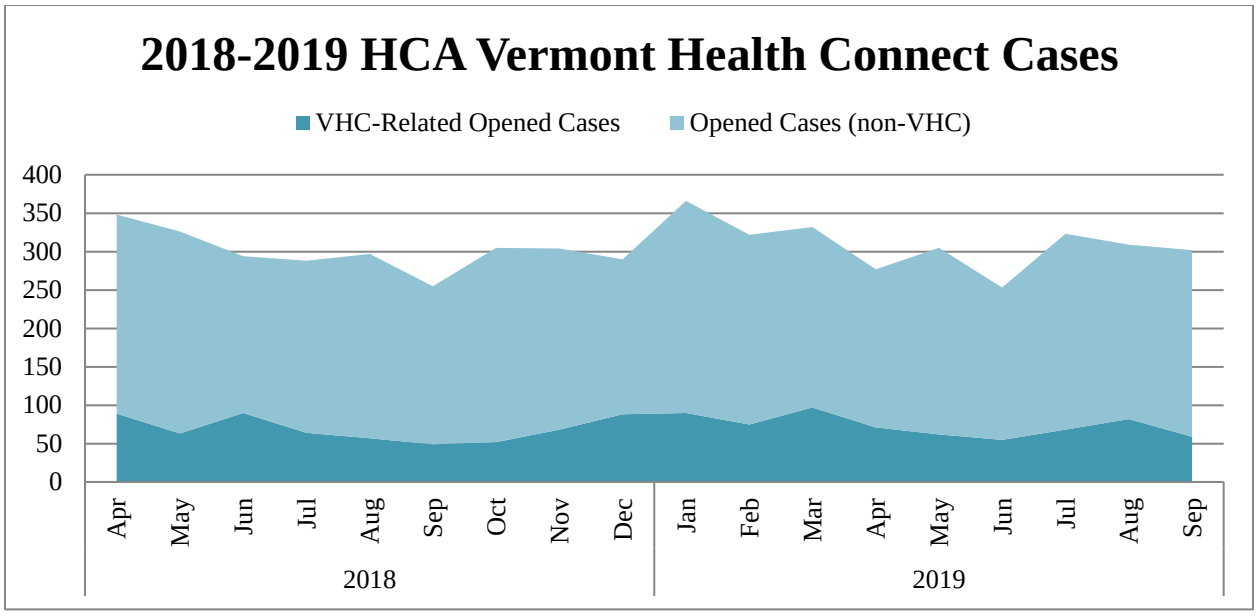
Total call volume increased by 12% (933 this quarter vs 835 last quarter). The HCA expects call volume for the next quarter to also remain high, because Medicare Part D open enrollment and Vermont Health Connect Open Enrollment will start. About 12% of this quarter's calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We also helped 61 households estimate their eligibility for insurance programs. We saved consumers $30,055.17 this quarter.

D. Calls concerning Vermont Health Connect increased by 9% this quarter.

The volume of calls concerning Vermont Health Connect increased this quarter (208 vs. 191). The top three VHC issues were Eligibility for Medicaid - MAGI (80), Premium Tax Credit Eligibility (76), and Eligibility for Special Enrollment Periods (57). This quarter, 73 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and another 32 cases required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC as needed to discuss cases, and has regular email contact with Tier 3. This quarter we had 39 escalated cases (41 last quarter). Of the 39 escalated cases, 31 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spend Downs). This quarter we continued to receive significant numbers of consumers calling with questions about Medicare Savings Programs (57), MABD (68), Medicaid Spend Downs (22) and VPharm eligibility (21)).



E. Medicaid eligibility calls represented 28% of all our cases (259 cases/933 total cases). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 127 calls about eligibility for Medicaid for Children and Adults (MCA) Medicaid, 68 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 22 about Medicaid Spend Downs, and 14 about Medicaid for Working Disabled, and 3 about Katie Beckett Medicaid. We also had 25 calls about Long Term Care Medicaid. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spend Down, how to complete renewal paperwork, and whether their eligibility decision is correct.

F. The top issues generating calls

The listed issues in this section include both primary and secondary issues, so some of these may overlap.

All Calls 933 (compared to 835 last quarter)

1. MAGI Medicaid eligibility 127 (125)
2. Complaints about providers 107 (76)
3. Premium Tax Credit eligibility 82 (62)
4. Information/applying for DVHA programs 74 (74)
5. Not health related 74 (54)
6. Eligibility for Special Enrollment Periods 73 (77)
7. Access to Prescription Drugs/Pharmacy 70 (47)
8. Medicaid eligibility (non-MAGI) 68 (57)

9. Information about Medicare 67 (69)
10. Buy-in programs/Medicare Savings Programs 57 (57)
11. Nursing Home & Home Health access 43 (42)
12. Affordability affecting access to care 38 (59)
13. Other Health Related concerns 38 (31)
14. Billing Coverage and Contract questions 29 (28)
15. Complaints about VHC – Invoices or Payment 29 (29)

Vermont Health Connect Calls 208 (compared to 191 last quarter)

1. MAGI Medicaid eligibility 80 (78)
2. Premium Tax Credit eligibility 76 (58)
3. Eligibility for Special Enrollment Periods 57 (64)
4. Termination of Insurance 42 (62)
5. Information about DVHA 38 (24)
6. Information about Grace Periods 27 (30)
7. Fair Hearing – Eligibility 25 (30)
8. Complaints about VHC – Invoices or Payment 25 (26)
9. IRS Reconciliation 21 (19)
10. Affordability affecting access to care 20 (27)
11. Buying QHPs through VHC 20 (27)

DVHA Beneficiary Calls 309 (compared to 308 last quarter)

1. MAGI Medicaid eligibility 56 (63)
2. Medicaid eligibility (non-MAGI) 31 (35)
3. Access to Prescription Drugs/Pharmacy 27 (21)
4. Complaints about providers 26 (27)
5. Information about DVHA 25 (34)
6. Information about Medicare 23 (20)
7. Access to transportation 21 (16)
8. Balance Billing 19 (14)
9. Information about HCA 19 (11)
10. Buy In Programs/MSPs eligibility 19 (23)
11. Not health related 19 (19)

Commercial Plan Beneficiary Calls 162 (compared to 171 last quarter)

1. Premium Tax Credit eligibility 38 (30)
2. Eligibility for Special Enrollment Periods 21 (32)
3. MAGI Medicaid eligibility 19 (22)
4. Complaints about VHC - Invoices or Payment 18 (20)
5. Affordability affecting access to care 17 (20)
6. Information about Grace Periods 16 (16)
7. Access to Prescription Drugs/Pharmacy 14 (##)
8. Coverage & Contract Questions 14 (13)
9. Premiums billing 13 (22)
10. Information about ACA (13) (11)

The HCA received 933 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 33.1% (309 calls)l compared 36.8% (307 calls)last quarter
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 26.7% (250 calls) compared to 32.2% (269 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 17.3% (162 calls), compared to 20.4% (170 calls)last quarter
- **Uninsured:** 9.6% (90 calls) compared to 7.66% (64 calls last quarter.

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 973 cases this quarter, compared to 816 last quarter:

- 38% (371 cases) were resolved by brief analysis and advice
- 28% (273) were resolved by brief analysis and referral
- 20% (191) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 11% (106) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases, 32 clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA worked on 64 cases related to appeals: 32 Fair Hearings; 8 Commercial Insurance appeals; 7 Medicare Part A, B, or C appeals; 4 Medicare Part D appeals; and 13 Medicaid MCO Internal appeals.

DVHA Beneficiary Calls

We closed 324 DVHA cases this quarter, compared to 300 last quarter:

- 36% (116 cases) were resolved by brief analysis and/or advice
- 23% (76) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 22% (70) were resolved by brief analysis and/or referral
- 17% (56) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases, 6 clients resolved the issue on their own, or had some other outcome.

[2] Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with the figures for those categories.

Commercial Plan Beneficiary Calls

We closed 180 cases involving individuals on commercial plans, compared to 172 last quarter:

- 43% (77 cases) were resolved by brief analysis and/or advice
- 27% (49) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 16% (28) were resolved by brief analysis and/or referral
- 10% (18) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases, 8 clients withdrew, resolved the issue on their own, or had some other outcome.

B. All Calls Case Outcomes

The HCA helped 530 people with advice and education about health insurance questions or problems. We obtained insurance for 72 households. We assisted 9 people with applications for or enrollment in insurance plans and prevented 18 insurance terminations or reductions. We obtained coverage for services for 22 people. We got 4 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 61 more. We provided other billing assistance to 27 individuals. We obtained other access or eligibility outcomes for 78 additional people.

Consumer Protection Activities

A. Rate Review

The HCA analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. Insurers typically request an increase in the premium prices that Vermonters must pay.

The Board decided two filings during the quarter from July 1, 2019 through September 30, 2019. Additionally, there was one proposed premium price increase pending at the end of this quarter.

Blue Cross Blue Shield of Vermont (BCBSVT) submitted one of the filings decided by the Board this quarter, namely, the BCBSVT Individual and Small Group Rate Filing (BCBSVT "Exchange" filing). Approximately 43,900 Vermonters who obtain coverage through their small employers, Vermont Health Connect, or directly through BCBSVT were impacted by this filing. BCBSVT filed for an average increase of 15.6% for this book of business. The HCA appeared on behalf of Vermonters, filed questions to the carrier, filed various motions, represented the interests of Vermonters at the public hearing for this filing, and submitted a post-hearing memorandum in this matter. As we discuss below, the HCA engaged in multiple strategies to facilitate public comment on this filing including, but not limited to, the development and implementation of a web public comment tool. The Board reduced BCBSVT's average rate increase to approximately 12.4%.

MVP Health Plan, Inc. (MVP) submitted the other filing decided by the Board this quarter, namely, the MVP Individual and Small Group Rate Filing (MVP "Exchange" filing). Approximately 30,887 Vermonters who obtain coverage through their small employers, Vermont Health Connect, or directly through MVP were impacted by this filing. MVP originally filed for an average increase of 9.6% for this book of business and it subsequently amended its proposed increase to 11.0%. The HCA appeared on behalf of Vermonters, filed questions to the carrier, filed various motions, represented the interests of Vermonters at the public hearing for this filing, and submitted a post-hearing memorandum in this matter. As discussed below, the HCA engaged in multiple strategies to facilitate public comment on this filing including, but not limited to, the development and implementation of a web public comment tool. The Board reduced MVP's average rate increase to approximately 10.1%.

The HCA engaged in substantial efforts during the reporting quarter to facilitate increased public comment on the two filings decided this quarter. Activities included direct outreach, development and deployment of a web public comment tool, media public awareness campaigns, and outreach to consumer interest organizations. The number of submitted public comments on the two "Exchange" filings increased substantially this year. In 2016, Vermonters submitted 120 written comments on the "Exchange" filings. Vermonters submitted 114 written comments in 2017 and 168 written comments in 2018. This year, the Board received roughly 620 written public comments on the "Exchange" filings. Of the roughly 620 written public comments submitted to the Board on the "Exchange" filings approximately 440 spoke the lack of affordability of premium prices. Roughly 128 of the 620 written comments made explicit reference to the unaffordable out-of-pocket costs associated with health insurance plans.

There is one premium price increase request pending at the end of this quarter (the combined MVP Large Group and POS Rider filings). The HCA appeared on behalf of Vermonters in this matter and submitted questions to the carrier. We intend to file all appropriate memoranda and other documents to represent the interests of Vermonters in this matter.

B. Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process. This quarter, the HCA reviewed the fourteen hospital budgets submitted to the Board. These submissions included answers to our first set of written questions which were included in the Board's budget guidance. After reviewing the materials, we submitted a set of follow-up questions for the hospitals to be discussed during the hearings. The HCA participated in each hospital budget hearing, including asking questions of each hospital. Our questions were focused on affordability, free care, bad debt, and patient financial assistance. Following the hearings, we submitted written comments outlining our concerns about the budgets and asking the Board not to approve a rate increase for UVM Medical Center. HCA staff attended all the public meetings at which the Board deliberated and then voted on each hospital's budget. The Board approved a lower rate increase for UVM Medical Center than the hospital had requested, but did not accept the HCA's recommendation to forego a rate increase entirely.

C. Oversight of Accountable Care Organizations

The HCA participates in the Board's annual ACO budget review process. This quarter, the HCA submitted questions for OneCare to respond to along with its 2020 budget submission to the Board. These questions included asking for year-over-year quality data and for any lessons OneCare learned based on its 2017 and 2018 quality and financial outcomes. We are also meeting regularly with Board staff to discuss ACO budget oversight as the regulatory season progresses.

D. Certificate of Need Applications

This quarter, the HCA continued to monitor new certificate of need applications and updates from previously approved certificate of need projects submitted to the Board. We will intervene for any projects where we have significant consumer protection concerns.

E. Other Green Mountain Care Board Activities

The HCA continues to attend the weekly Board meetings. The Chief Health Care Advocate met individually with board members late in the quarter to touch base about our work on the Board's regulatory processes.

F. Other Activities

Administrative Advocacy

Rural Health Task Force

The Rural Health Task Force was formed as directed by Act 26 of 2019. This taskforce is made up of a broad range of provider groups who focus on rural health care delivery in Vermont. After organizing itself, and selecting a chair, the group defined a number of areas of focus including: workforce, distribution of health care infrastructure, and care management/integration. The task force will report its recommendations to the legislative committees of jurisdiction by January 15th of 2020

Definition of Primary Care Work Group

The HCA participated in the Primary Care work group defined in Act 107 of 2019. The work group's membership includes Vermont Association of Hospitals and Health Systems, BiState primary Care, Green Mountain Care Board, the Agency of Human Services, Department of Vermont Health Access, the Blueprint for Health, OneCare Vermont, Vermont Medical Society, Blue Cross/Blue Shield, MVP Healthcare, and the office of the Health Care Advocate. This work group first reviewed both state and national definitions of primary care. It then compared those standards to determine the best standard for Vermont. The group reached significant consensus around a broadly-inclusive definition of primary care. This standard may not be particularly useful as a tool to compare Vermont primary care spending to other states or countries, due to significant variations in the definition of primary care. It will, however, provide a useful benchmark to measure expansion or contraction of primary care spending in Vermont over the years.

- **University of Vermont Medical Center Mental Health Program Quality Committee**

The HCA continues to participate in the UVMMC Mental Health Program Quality Committee (PQC). The PQC meets monthly and discusses mental health quality, programs, infrastructure, and planning.

- **Vermont Health Information Exchange Consent Policy**

The HCA advocated for meaningful informed consent for patient participation in Vermont's Health Information Exchange. The HCA engaged with state partners to assure that there is a robust outreach and communications plan to ensure that Vermonters understand how and why their health information will be shared. We participated in two meetings to discuss the outreach and communication plan.

- **Hospital-Associated Infections Advisory Committee**

The HCA provided a health care consumer perspective during the September meeting, regarding surveillance of antimicrobial resistance and WHONET.

- **Global Commitment Register Comments**

The HCA continues to monitor Global Commitment rule and policy changes. This quarter we reviewed several proposed rule and policy changes.

- **Vermont Health Connect Escalation Path**

The HCA and VHC continue to collaborate to resolve complex VHC issues. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spend Downs, and V-Pharm. We communicate with VHC multiple times per day and meet as needed to discuss the most difficult cases.

- **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 9 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate continued to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB). This quarter, the MEAB membership had a particular focus on Medicaid budget priorities. After hearing a presentation by the Department of Health Access, the MEAB discussed the values and priorities that they believe should be the underpinning of Medicaid budget development. These values and priorities were expressed in a letter to the Commissioner. The MEAB also focused on telemedicine and Success Beyond Six this quarter. The Chief attended and co-chaired two meetings of the MEAB this quarter.

✧ **Gender Affirming Surgery**

The HCA continues to advocate for increased access to medically-necessary gender affirming surgery for gender dysphoria. This quarter, the HCA continued coordinating outreach to transgender and non-binary consumers, as well as local and regional stakeholder organizations on the topic of gender affirming treatment for gender dysphoria in preparation for DVHA's July 2019 public hearing and the LCAR hearing in October 2019. The HCA attended the public hearing and also submitted additional written comments during this comment period. In our comments and outreach, the HCA's priorities are ensuring that Medicaid is accurately determining medical necessity while decreasing onerous barriers to access to care for Vermonters with gender dysphoria.

Legislative Activities

The HCA participated in various legislatively-defined work groups including, the Rural Health Services Task Force, Vermont Health Information Exchange Opt-Out Consent Policy implementation, Definition of Primary Care work group, Dental Access and Reimbursement Working Group and the Price Transparency Billing Processes stakeholder group. Other legislatively-defined stakeholder groups were not formed or did not meet during the quarter including the Health Insurance Affordability Report and the Merged Insurance Markets report.

The HCA was available and responsive to numerous legislator inquiries about policy issues and constituent access to care issues during this quarter. In addition, the Chief Health Care Advocate initiated meetings with various key legislators to discuss the coming session.

Collaboration with Other Organizations

The HCA regularly collaborates with other organizations to advance consumer-oriented policy objectives and to conduct outreach and education. We worked with the following organizations this quarter:

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Burlington School District
- Community Catalyst
- Families USA
- IRS Taxpayer Advocate Service
- MVP Health Care
- National Center for Transgender Equality

- NHeLP, National Health Law Program
- OneCare Vermont
- Out in the Open (formerly Green Mountain Crossroads)
- Outright Vermont
- Pride Center of Vermont
- Planned Parenthood of Northern New England
- Rights and Democracy Vermont
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Businesses for Social Responsibility
- Vermont Care Partners
- Vermont CARES
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Developmental Disabilities Council
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- Vermont Workers' Center
- You First

Outreach and Education

Quarterly report – website stats – July - Sept 2019

*Note: Office pageviews of the health web pages are included in the numbers here. The **only** numbers where office traffic is **excluded** are the Online Help Tool numbers.*

A. Increasing Reach and Education through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 180 pages of consumer-focused health information maintained by the HCA.

HCA advocates work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

- The total number of **health pageviews increased by 31%** in the reporting quarter ending September 30, 2019 (15,128 pageviews), compared with the same quarter in 2018 (11,534 pageviews). A reason for some of the increase is that the website was upgraded in July and more pages were viewed after the upgrade to be sure everything was working well.

- The **top-20 health pages** on our website this quarter with change over last year:
  - *Income Limits – Medicaid* – 2,451 pageviews (23% ↓)
  - *Health* – section home page – 1,491 (1% ↓)
  - *Dental Services* – 788 (92% ↑)
  - *Buying Prescription Drugs* – 673 (175% ↑)
  - *Medicaid* – 462 (105% ↑)
  - *Services Covered by Medicaid* – 439 (2% ↓)
  - *Choices for Care* – 354 (20% ↓)
  - *Resource Limits – Medicaid* – 351 (17%↓)
  - *Medicare Savings / Buy-In Programs* – 309 (55% ↑)
  - *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 308 (170% ↑)
  - *Medical Decisions: Advance Directives* – 284 (122% ↑)
  - *HCA Help Request Form* – 283 pageviews (47% ↑) and 75 online help requests (56% ↑)
  - *Long-term Care* – 270 (60% ↑)
  - *Supplemental Plans Medicare* – 262 (608% ↑)
  - *Advance Directive Forms* – 228 (21% ↑)
  - *Federally Qualified Health Centers* – 204 (42% ↑)
  - *Choices for Care Requirements* – 197 (40% ↑)
  - *Prescription Help – State Pharmacy Programs* – 192 (160% ↑)
  - *Choices for Care Income Limits* – 192 (9% ↑)
  - *Medicaid and Medicare Dual Eligible* – 188 (9% ↑)

- Besides the pages listed above, other **spikes in interest** in our pages included:
  - *Dr. Dynasaur* – 181 pageviews (69% ↑)

- *Medicare* – 177 (354% ↑)
- *Vermont Health Connect main page* – 155 (96% ↑)
- *Health Insurance main page* – 150 (63% ↑)
- *Medicare Part D Costs* – 119 (440% ↑)
- *Health Insurance Premium Increases 2019* – 108 (100% ↑)

Popular Downloads

17 different health care-related PDF, Word, or other files were downloaded from the VTLawHelp.org website. Of those unique health-related titles:

- The top five consumer-focused downloads were:
  - *Advance Directive, short form* (152 downloads)
  - *Advance Directive, long form* (94 downloads)
  - *Vermont Dental Clinics Chart* (71 downloads)
  - *Vermont Medicaid Coverage Exception Standards flyer* (55 downloads)
  - *Fair Hearing Flyer* (22 downloads)
- The top advocate-focused download was:
  - *PTC Rule Allocation Spreadsheet* (13 downloads)

The *Advance Directive Short Form* is the **fourth most downloaded of all PDFs** downloaded from the entire VTLawHelp.org website. The *Long Form* is the **sixth most downloaded**. The *Vermont Dental Clinics Chart* is the **tenth most downloaded**.

Online Help Tool Adds to Our Reach

Health is one of the topics in the online help tool on our website. It can be accessed from most pages of our website *https://vtlawhelp.org/triage/vt_triage*. *This tool was recognized in an article by the Pew Charitable Trusts in October 2019*.

The website visitor answers a few questions to find specific health care information they need. The tool addresses some of the most popular questions that are posed to the HCA. In addition to our deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this tool to access health care information **127 times** during this quarter. That's down from the same quarter last year as well as the previous quarter of this year.

Of the **44** health care topics that were accessed using this tool, the top topics were:

- Dental Services – I need help finding a low-cost dentist and paying for dental care.
- Medicaid – I want to apply for Medicaid or Dr. Dynasaur for myself or for my children.
- Complaints – I want to file a complaint against a doctor or hospital.
- Long-Term Care – How do I know if I can get Choices for Care Long-Term Care Medicaid?

B. Other Outreach and Educational Activities

- **Rate Review Outreach, July, 2019.** The HCA completed in-person outreach to small businesses and organizations in Montpelier and distributed information by email to organizations and business networks across the state.
- **Racial Equity Meeting, July 11, 2019.** The HCA participated in discussions about equity in health care access and affordability. Three HCA staff also distributed business cards and info about HCA services and policy advocacy.
- **The Old North End Ramble, July 27, 2019.** The HCA tabled at the festival and distributed information about health care legal services. HCA reached 50 families, parents of young children, and other community members.
- **Department of Mental Health Burlington Forum, July 20, 2019.** The HCA participated in discussions about improving Vermont's mental health systems, shared information about the HCA's services with attendees, and distributed business cards.
- **Parent University Community Partner Organization Meeting, August 22, 2019.** The HCA handed out business cards and shared information on referring clients to the HCA and which services the HCA provides.
- **Northern Counties Health Care Outreach, August 23, 2019.** The HCA discussed trends in patient health insurance issues, how the HCA can be a resource for Assisters, and how to refer clients to the HCA. The HCA also provided general information about health insurance resources and applications.
- **Vermont Pride, September 9, 2019.** The HCA distributed information about health care access, answered general health insurance questions, and handed out letter openers and business cards with HCA helpline information. The HCA also shared updates about legislative advocacy. The HCA reached 60 members of Vermont's LGBTQ community.
- **Bennington Medical Site Visits, September 25, 2019.** The HCA Chief met with the Bennington Free Clinic and the Southwestern Vermont Medical Center, to discuss referrals, trends in health care issues, and how the HCA can be a resource for patients.
- **Social Media Outreach.** The HCA published 13 posts on Facebook, with a total of 4,612 views. The HCA published 25 posts on Twitter. The HCA published outreach information on Front Porch Forum reaching approximately 187,000 Vermont households.

C. Promoting Plain Language in Health Communications

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Open Enrollment October Stuffer RE002
- Open Enrollment Notice
- Open Enrollment Notice : regarding whether Vermonters need to enroll in health insurance
- OE202: Open Enrollment Notice
- EE515-MNT: Exceptional Circumstance SEP Denial
- EE718-MNT: Exceptional Circumstances SEP, more information requested,
- Notice on Pursuit of Unearned Income
- Follow up Notice on Pursuit of Unearned Income
- EE002-Request for Additional Information

Office of the Health Care Advocate

Vermont Legal Aid
264 North Winooski Avenue
Burlington, Vermont 05401
800.917.7787

https://vtlawhelp.org/health

Attachment 6 - GC Investments

CY 2019 Investment Expenditures

Department	STC #	Receiver Suffix	Investment Description	QE 0319	QE 0619	QE 0919	QE 1219	CY 2019 Total
AHSCO	41	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,067	113,067	113,101		**339,235**
AHSCO	54	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	3,309,488	1,615,107	1,684,460		**6,609,055**
AOE	11	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	55	9402	Investments (STC-79) - Medical Services (55)	23,713	16,960	27,382		**68,056**
DCF	1	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,232,488	2,163,050	2,364,167		**6,759,705**
DCF	56	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,047,295	697,313	1,373,316		**3,117,924**
DCF	57	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	27,795	18,726	37,520		**84,041**
DCF	58	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	68,004	44,134	89,955		**202,093**
DCF	59	9408	Investments (STC-79) - Essential Person Program (59)	209,725	209,216	207,565		**626,506**
DCF	60	9409	Investments (STC-79) - GA Medical Expenses (60)	70,191	83,423	46,007		**199,621**
DCF	61	9411	Investments (STC-79) - Therapeutic Child Care (61)	285,108	303,798	344,393		**933,299**
DCF	2	9412	Investments (STC-79) - Lund Home (2)	366,961	697,058	679,793		**1,743,812**
DCF	33	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	-	-	-		**-**
DCF	34	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	44,660	101,852	60,572		**207,084**
DCF	9	9415	Investments (STC-79) - Challenges for Change: DCF (9)	48,807	20,545	44,742		**114,094**
DCF	26	9416	Investments (STC-79) - Strengthening Families (26)	308,531	272,857	329,223		**910,610**
DCF	62	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	68,790	65,921	45,782		**180,494**
DCF	35	9418	Investments (STC-79) - Building Bright Futures (35)	206,047	148,849	115,376		**470,272**
DDAIL	63	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	120,100	66,080	122,709		**308,889**
DDAIL	64	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	353,476	856,447	83,779		**1,293,701**
DDAIL	27	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	289,997	193,985	-		**483,982**
DDAIL	42	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)	-	-	-		**-**
DDAIL	43	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	232,386	282,202	318,148		**832,736**
DDAIL	77	9607	Investments (STC-79) - HomeSharing (77)	86,397	86,312	84,939		**257,648**
DDAIL	78	9608	Investments (STC-79) - Self-Neglect Initiative (78)	110,761	69,406	66,292		**246,459**
DDAIL	65	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	16,175	17,153	16,734		**50,062**
DMH	28	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	38,771	33,410	11,930		**84,110**
DMH	66	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	665,517	645,037	728,097		**2,038,651**
DMH	79	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	130,269	111,612	112,321		**354,202**
DMH	16	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(5,624,184)	(834,225)	(2,309,280)		**(8,767,689)**
DMH	12	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,096,710	662,760	656,147		**2,415,617**
DMH	29	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,723,842	1,595,744	1,258,706		**5,578,292**
DMH	67	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	465,823	158,672	194,375		**818,870**
DMH	22	9510	Investments (STC-79) - Emergency Support Fund (22)	287,906	75,706	107,393		**471,005**
DMH	3	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	5,513,064	4,779,527	5,587,349		**15,879,939**
DMH	3	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	1,390,537	2,610,673	927,225		**4,928,435**
DMH	68	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	11,939	41,947	18,760		**72,646**
DMH	13	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	43,293	436,132	143,984		**623,409**
DOC	4	n/a	Return House	117,936	135,666	134,109		**387,711**
DOC	5	n/a	Northern Lights	98,438	98,438	98,438		**295,314**
DOC	6	n/a	Pathways to Housing - Transitional Housing	278,587	383,103	137,049		**798,739**
DOC	14	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	130,237	62,365	135,464		**328,066**
DOC	15	n/a	Northeast Kingdom Community Action	-	-			**-**
DOC	69	n/a	Intensive Substance Abuse Program (ISAP)	-	-			**-**
DOC	70	n/a	Intensive Domestic Violence Program	-	-			**-**
DOC	71	n/a	Community Rehabilitative Care	-	1,364,230	788,919		**2,153,149**
DOC	80	n/a	Intensive Sexual Abuse Program	2,500	2,720	-		**5,220**
DVHA	8	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	-	-			**-**
DVHA	51	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	770,216	823,697	681,434		**2,275,347**
DVHA	52	9103	Investments (STC-79) - Buy-In (52)	14,170	10,699	8,808		**33,677**
DVHA	53	9104	Investments (STC-79) - HIV Drug Coverage (53)	682	682	682		**2,046**
DVHA	18	9106	Investments (STC-79) - Patient Safety Net Services (18)	-	-	-		**-**
DVHA	7	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	2,306,138	2,716,620	2,801,713		**7,824,470**
DVHA	72	9108	Investments (STC-79) - Family Supports (72)	-	-	-		**-**
DVHA	81	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)	-	-	-		**-**
DVHA	82	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)	-	-	-		**-**
GMCB	45	n/a	Green Mountain Care Board	437,029	717,531	601		**1,155,161**
UVM	10	n/a	Vermont Physician Training	844,804	844,805	337,288		**2,026,897**
VAAFM	36	n/a	Agriculture Public Health Initiatives	-	-	-		**-**
VDH	19	9201	Investments (STC-79) - Emergency Medical Services (19)	123,846	116,394	130,864		**371,104**
VDH	74	9203	Investments (STC-79) - TB Medical Services (74)	10,095	15,236	9,467		**34,798**
VDH	40	9204	Investments (STC-79) - Epidemiology (40)	174,421	322,332	267,704		**764,457**
VDH	39	9205	Investments (STC-79) - Health Research and Statistics (39)	270,241	304,300	283,771		**858,313**
VDH	31	9206	Investments (STC-79) - Health Laboratory (31)	810,186	959,944	738,077		**2,508,206**
VDH	50	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	210,907	818,988	360,567		**1,390,462**
VDH	76	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)	-	-	-		**-**
VDH	75	9209	Investments (STC-79) - Family Planning (75)	406,196	400,950	415,808		**1,222,954**
VDH	25	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	18,722	-	515,294		**534,016**
VDH	73	9211	Investments (STC-79) - Renal Disease (73)	-	-	-		**-**
VDH	37	9213	Investments (STC-79) - WIC Coverage (37)	808,915	1,054,030	593,183		**2,456,128**
VDH	21	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	268,800	-	125,000		**393,800**
VDH	47	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,065	15,299	13,500		**40,864**
VDH	30	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	473,797	512,894	471,088		**1,457,779**
VDH	17	9220	Investments (STC-79) - Recovery Centers (17)	310,887	327,846	61,033		**699,765**
VDH	46	9221	Investments (STC-79) - Enhanced Immunization (46)	90,214	21,081	32,994		**144,288**
VDH	48	9222	Investments (STC-79) - Poison Control (48)	26,246	28,252	28,252		**82,750**
VDH	23	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	279,443	475,636	273,485		**1,028,564**
VDH	38	9224	Investments (STC-79) - Fluoride Treatment (38)	14,144	15,440	14,368		**43,952**
VDH	24	9225	Investments (STC-79) - Medicaid Vaccines (24)	-	-	-		**-**
VDH	49	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	58,791	48,459	47,031		**154,281**
VDH	44	9228	Investments (STC-79) - VT Blueprint for Health (44)	466,192	283,982	244,284		**994,457**
VSC	32	n/a	Health Professional Training	204,730	-	204,731		**409,461**
VVH	20	n/a	Vermont Veterans Home					**-**
				26,423,019	**31,342,075**	**25,647,968**	**-**	**83,413,062**

Attachment 7a - Investment Scorecard - VDH Health Laboratory

What We Do

Toxic agents are associated with increased mortality from cancer, respiratory, and cardiovascular diseases, and are the 5th leading actual cause of death in the U.S. Microbial agents are the fourth leading actual causes of death. Funding supports the Organic Program, the Microbiology Program and the Inorganic Program.

Who We Serve

This public health laboratory ensures access to quality health care by ensuring that all citizens can obtain lab services for public health priority conditions.

How We Impact

Investment objective:

Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries

Budget Information

SFY18 Costs: $3,245,097

% allocated to Global Commitment investment: 60.9%

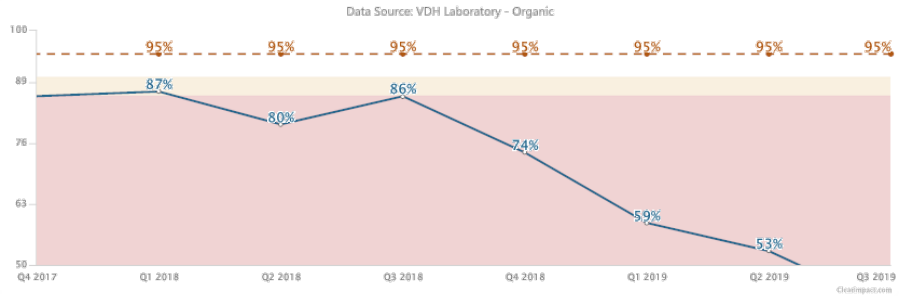
Performance Monitoring Plan

The Vermont Department of Health will monitor this plan in two ways:

1. The Performance Management Committee will review all investment programs and associated performance measures annually.
2. Commissioners and Division Directors will review selected measures at bi-weekly leadership meetings.

Performance Measures

	Most Recent Period	Current Actual Value
PM GCI % of urine drug screen negative test results reported within 24 hours from receipt at the laboratory		



Q3 2019	41%
Q2 2019	53%
Q1 2019	59%
Q4 2018	74%
Q3 2018	86%
Q2 2018	80%
Q1 2018	87%
Q3 2017	85%
Q2 2017	62%

Story Behind the Curve

A urine drug test, also known as a urine drug screen or a UA uses either a rapid immunoassay or chromatographic method to analyze human urine for the presence of certain illegal drugs and prescription medications. The urine drug testing VDHL screens for seventeen substances such as, amphetamines, methamphetamines, benzodiazepines, barbiturates, marijuana, cocaine, PCP, methadone, and opioids (narcotics).

The VDHL's stretch goal is to report test results, for specimens which are negative, to our customers within 24 hours from the time the specimen is received.

Partners

The Vermont Department of Health Laboratory (VDHL) serves the Department of Children and Families District Offices, Department of Corrections as well as medical providers throughout the state by performing Urine Drug Screening at a low cost.

The data generated helps with treatment for addiction while also protecting vulnerable persons from possible harm.

Testing for the presence of drugs in urine is regulated by the Centers for Medicare and Medicaid Services Clinical Laboratory Improvement Act (CLIA), resulting in the VDHL being audited every two years by CMS regulatory staff.

What Works

Receiving urine specimens in a timely manner through overnight Fed-Ex shipments or courier and meeting testing specimen requirements allows the VDHL to analyze and report negative results within the 24-hour goal. Receiving urine specimens in the correct collection containers (not leaking) and with the required information enables laboratory staff to analyze and report test results without delay. Urine specimens received with missing information, requires laboratory staff to contact the submitter and resolve the issue.

Action Plan

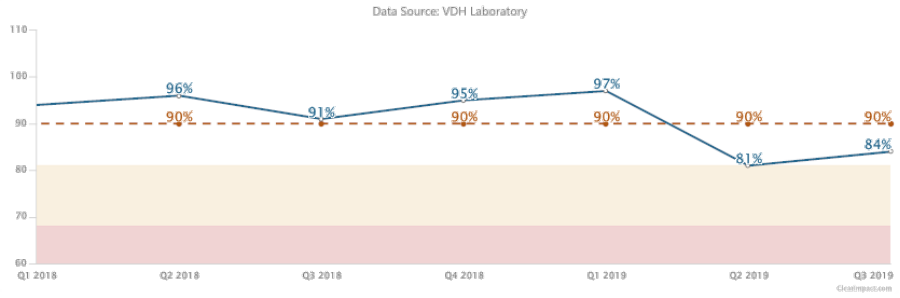
The VDHL will continue communicating with Partners regarding the required information that is needed on the test request form that will lead to less issue resolution and more test results being reported within the 24-hour goal. A quality monitor will be completed that will document the submitter and the missing information and will be used to improve clarity of instructions that are used use for sample submission. Laboratory staff will continue to visit submitter offices such as DCF, to provide guidance regarding the completion of testing forms, specimen collection practices, and specimen packaging to decrease the likelihood of a delayed test result.

The VDHL is working with the Agency of Digital Services to launch a new Lab Web Portal in December 2019. This portal will allow providers to request tests and receive results online from the VDHL. The portal will be a shift from paper/fax/email communications to an online solution which will improve efficiencies as well as reduce the opportunities for data entry errors for both the laboratory and our partners.

Why Is This Important?

Results from a urine drug test can help confirm use of drugs by the client or patient and detect potential substance abuse problems, which helps to initiate treatment plans for addiction as well as protecting vulnerable persons from possible harm.

PM GCI % of tuberculosis specimens received within 2 calendar days of specimen collection



Q3 2019	84%
Q2 2019	81%
Q1 2019	97%
Q4 2018	95%
Q3 2018	91%
Q2 2018	96%
Q4 2017	92%
Q3 2017	94%
Q2 2017	93%

Story Behind the Curve

Tuberculosis (TB) is a bacterial lung disease caused by Mycobacterium tuberculosis. It is transmitted primarily by airborne droplets produced when someone with pulmonary tuberculosis sneezes, coughs, or speaks. In the United States, the number of tuberculosis cases reported annually declined steadily between 1953 and 1985. After years of declining case rates, tuberculosis was again a major public health problem in the United States with the emergence of human immunodeficiency virus (HIV). In the early 90's serious outbreaks of multi-drug resistant TB were also recognized. In response to these events, several scientists published "The Resurgence of Tuberculosis: Is Your Laboratory Ready?" to describe the laboratory's role to in meeting the challenges posed by MDR-TB. Optimizing laboratory facilities, methods and procedures were key features of meeting the challenge of resurging TB, especially MDR-TB. Prompt delivery of specimens to the laboratory was one of these key procedures because positive test results from one specimen impact infection control and treatment of the patient.

CDC Cooperative agreement funds were awarded to help upgrade state public health mycobacteriology (TB) laboratory facilities to meet the challenge of re-emerging TB. Promote the rapid delivery of specimens to the laboratory was established and continues to be a key metric that must be reported to CDC in response to the funding received.

Partners

Partners include the Vermont Department of Health Infectious Disease Epidemiology Program, the public health nurses at the Local Health offices within the Department of Health, hospital laboratories, and Infectious Disease physicians at UVM Medical Center, particularly Dr. Wallace K. “Kemper” Alston. The CDC is also a partner due to provision of federal grant funds to support test services.

What Works

The NECLA courier collects specimens from hospital laboratories around the state for twice daily week day delivery to the UVM Medical Center and the Vermont Department of Health Laboratory (VDHL). Rapid, direct detection of M. tuberculosis in respiratory specimens is available on demand at VDHL for patients who have not started TB treatment. All first time smear positive and provider requested respiratory specimens are tested at VDHL. The GeneXpert MTB/RIF Assay detects M. tuberculosis and resistance to the important TB treatment drug rifampin in sputum specimens received at VDHL. If rifampin resistance is detected by GeneXpert, the specimen is referred to CDC for gene sequencing, which allows rapid molecular detection of drug resistance.

Action Plan

The NECLA courier only collects specimens from hospital laboratories. Local Health public health nurses often supervise collection of sputum specimens from patients suspected of having TB. Special on-demand courier services need to be set up for these specimens and the series of three specimens collected for testing is often sent in a batch. The CDC recommendation is promote rapid delivery of specimens to the laboratory. The benchmark is receipt within 1 day of specimen collection. The national performance target is receive ≥67% of specimens within 1 day of specimen collection. The VDHL specific target is 80% delivered within 2 days. A routine VDHL courier route may improve specimen delivery by providing different pick up locations and possible 24/7 delivery and communication of a pending specimen pick-up at the Local Health Office is critical. Expansion to a daily, M-F state-wide courier service pick-up is ongoing.

Why Is This Important?

Patients suspected of having pulmonary tuberculosis may be placed in a hospital airborne infection isolation unit. Patients may also be directed to isolate themselves at home and curtail their daily activities while they await diagnosis. Rapid detection of tuberculosis allows the patient to begin the multiple months of observed drug therapy required to treat active TB disease. It also allows the Vermont Department of Health Infectious Disease Epidemiology Program to begin the contact investigation to discover who may have been exposed to pulmonary TB. GeneXpert MTB/RIF® Assay testing may also provide cost savings to the health care system by reducing the time a patient, who tests negative, spends in an expensive airborne isolation room.

PM GCI % of towns/communities served by VDHL water testing services

Story Behind the Curve

In Vermont estimates show that 30-40% of the population is served by a well or a spring. According to a data analysis conducted by the Environmental Health Division of the number and sampling locations of Kit A for Total Coliform Bacterial tests performed at the Vermont Department of Health Laboratory for 2011-2017, only about 11-14 % of those households with private water sources have had their water tested for bacterial contamination. Further data analysis of sampling locations indicated that the farther the distance of the residential private well or spring was from the VDHL, the less Total Coliform Bacterial tests were performed. Based on population and a low frequency of testing, the analysis also showed that St. Johnsbury and Springfield would be optimal targeted locations for broader educational outreach about “Testing Your Tap” and for the VDHL to establish a courier pick-up of drinking water samples at the Local Health Offices in those areas. The availability of a scheduled courier pick-up of drinking water samples in those locations should increase the number of residential water sources tested for bacterial contamination.

Partners

Partners include the Vermont Department of Health Environmental Health Division and Local Health Offices, DEC Drinking Water and Groundwater Protection Division, Home Inspectors, Town Health Officers, and the public.

What Works

The VDHL works closely with the VDH Environmental Health Division on how to increase the numbers of wells or springs tested for contaminants according to VDH recommendations. This includes review of communication initiatives to educate the public on the value of testing their water such as postings on Front Porch Forum, the VDH website, videos or targeted media campaigns. The Environmental Health Division staff has access and can query the VDHL laboratory information management system, STARLIMS, to extract and analyze all types of drinking water test data that is used for public health decision or policy making. Customer Service Program provides written guidance provided by the Environmental Health Division on "Testing Drinking Water from Private Supplies" to customers serviced at the laboratory's customer service window, as well as verbal guidance during telephone inquiries from homeowners needing assistance on what to test their water for. The VDHL currently has a contract for state-wide courier services that is currently used for pick-up of on-demand clinical specimens, VT Forest and Parks seasonal recreational water samples at the St. Albans Local Health Office and was also used during the School Lead Pilot Project for testing of drinking water in schools.

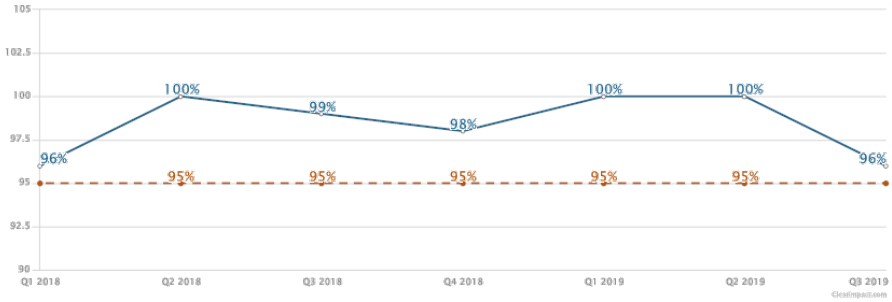
Action Plan

To increase the number of private water supplies that are tested for bacterial contamination in two, low testing frequency locations in the state, St. Johnsbury and Springfield, will be established as courier pick-up sites, once an initial pilot project for courier specimen pick-up for drinking water samples delivered by the public to a Local Health Office is completed. The VDHL will work with the Environmental Health and Local Health Divisions and the Health surveillance Communications Director to develop a communication plan to highlight the need for testing and the availability of sample pick-up. The courier will be scheduled by VDHL and outline the frequency and time of day that samples need to be at the location for pick-up.

Why Is This Important?

A Total Coliform bacterial test is recommended every year for homeowners with private wells. Coliform bacteria are a large group of soil and intestinal bacteria that indicate potential well contamination and may cause health problems. If Total Coliform bacteria are found, the water is then checked for E. coli bacteria. Test results show whether recent animal or human waste has entered the water. Water that has tested positive for bacterial contamination should not be consumed, unless boiled for one minute. Data has shown that only 11-15% of private drinking water sources are tested for bacterial contamination in Vermont. Establishing a regular courier pick-up of samples at predetermined locations throughout the state will alleviate a potential barrier, the cost and distance to deliver a sample to the VDHL, and result in increased number of bacterial tests performed on private residential water sources.

PM GCI % of blood lead samples tested within 7 business days



Q3 2019	96%
Q2 2019	100%
Q1 2019	100%
Q4 2018	98%
Q3 2018	99%
Q2 2018	100%
Q1 2018	96%
Q4 2017	100%

Story Behind the Curve

Lead is a highly toxic heavy metal, which was historically been used in a number of products, like paint, water pipes, and pipe solder. High levels of lead in the body can cause neurological damage, especially to developing children and pregnant women. The Vermont Department of Health Laboratory (VDHL) serves the VDH Local Health Offices as well as medical providers throughout the state by screening capillary blood specimens collected from children 1- 2 years of age for lead, using Graphite Furnace Atomic Absorption (GFAA). The VDHL also performs lead venous confirmation and adult testing. The VDHL's goal is to report test results to our customers within seven days from the time the specimen is received. Testing for levels of lead in blood is regulated by the Centers for Medicare and Medicaid Services Clinical Laboratory Improvement Act (CLIA), resulting in the VDHL being audited every two years by CMS regulatory staff.

Partners

Relevant partners include Vermont Department of Health [and State of New Hampshire] Healthy Homes, Lead Poisoning Prevention Programs (VTHHLPPP), Local Health Offices (and associated WIC clinics), Environmental Health and also hospitals or other health care providers. CDC is also considered a partner since test data is reported from VTHHLPPP to CDC.

What Works

VDHL notifies the provider and VTHHLPPP when screening indicates an elevated level of lead in the blood. Test results are e-mailed to VDH Local Health Offices to provide efficient and timely delivery of results. This outreach helps expedite venous confirmatory re-sampling and scheduling of home environment assessments to determine the source of lead contamination when indicated. The VDHL also reaches out to medical providers to gather missing specimen identification information and to answer sampling or protocol questions.

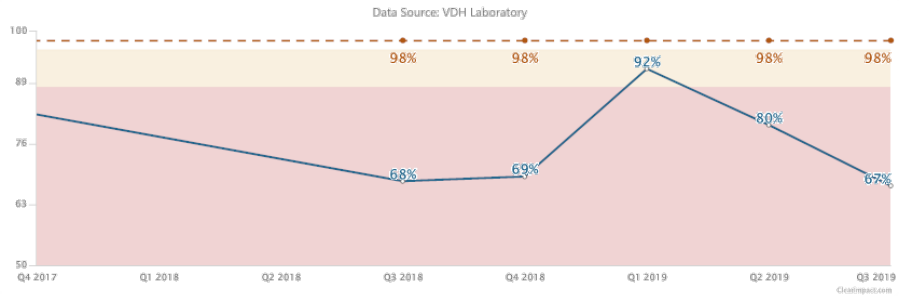
Action Plan

Electronic reporting of blood lead test results is scheduled for Phase 3 of the STARLIMS implementation project at the VDHL, which will decrease the time for providers to receive test results. The VDHL will also investigate the use of an alternate test method (the Ion-Coupled Plasma Mass Spectrometry or ICP-MS) that will provide a greater throughput of specimens in each test run. The VDHL will continue to support screening and confirmation blood lead testing and efforts to increase the rate of testing of children by medical providers and the testing of pregnant women for lead to further reduce the impact of environmental lead contamination on child development.

Why Is This Important?

Testing for blood lead in children and adults provides data that is important for individual health management and is the basis for triggering interventions that can prevent long-term exposure to lead in the environment, including your home.

PM GCI % of specimens related to rabies human exposure reported within 24 hours of receipt



Q3 2019	67%
Q2 2019	80%
Q1 2019	92%
Q4 2018	69%
Q3 2018	68%
Q3 2017	87%
Q2 2017	72%
Q1 2017	71%

Story Behind the Curve

Rabies is a deadly viral disease of the brain that infects mammals. The Vermont Department of Health Laboratory (VDHL) provides rabies diagnostic testing in animals, and also serves as a conduit for human rabies diagnostic testing that is performed at the CDC. Animal samples are primarily submitted from veterinarians, game wardens, animal control officers or the public. USDA Wildlife Services also submits approximately 20 brain stem samples per week as part of their rabies surveillance efforts, related to the efficacy of the oral rabies bait vaccine in the wildlife population. The VDHL also performs speciation of bats that are submitted to provide information to VT Fish and Wildlife about the levels of certain endangered species in the Vermont bat population. Rabies diagnostic testing includes an autopsy of the animal to remove certain brain sections needed for testing; preparation of brain tissue slides; staining of the slides with a highly specific anti-rabies reagent that is coupled with an apple-green florescent dye and reading of the stained slides under a fluorescent microscope to detect the apple-green fluorescent rabies virus particles or inclusions. Negative brain tissue will have no green fluorescence present. While VDHL test results are usually reported within 24-48 hours of receipt, our stretch goal is to report rabies test results within 24 hours from receipt for samples that are submitted due to human exposure from a potentially rabid animal bite or contact with saliva or central nervous system tissue. Samples received on Friday afternoons, Saturdays or holiday weekends will be reported within the usual 24-48 hour timeframe.

For human exposure cases, slides from each test animal are read by two microbiologists. The double read should occur on the same day as staining if possible. If an animal is tested on the weekend and is a human exposure case, a preliminary result is provided by the microbiologist who is on call for the weekend. Slides are read on the next working day as soon as possible by a second microbiologist who will provide a final result.

Partners

Partners include the Vermont Department of Health Infectious Disease Epidemiology Program, Vermont Fish and Wildlife, USDA Wildlife Services (including the VT Rabies Hotline), veterinarians, local animal control officers, Town Health Officers, VT Department of Agriculture, New York State Wadsworth Center Public Health Laboratory (for training and technical consultation), nuisance animal Wildlife Specialists, local and state law enforcement, medical providers (including hospital emergency department personnel) and the public. CDC is also a partner as it serves as reference laboratory for human rabies diagnostic testing and overall consultation.

What Works

The USDA Wildlife Services VT Rabies Hotline works in conjunction with the VDH Epidemiology Infectious Disease Program to respond to inquiries regarding rabies. The VDH Infectious Disease Epidemiology Program is available 24/7 to respond to human exposure and exposure to domestic animal/pet incidents and approve all diagnostic rabies sample submissions to the VDHL. The samples are safely packaged and submitted primarily in a VDHL rabies kit that is available through the VDHL, State Game Wardens, veterinarians etc. VDHL rabies staff are available 365 days/year to respond for testing of an animal that is involved in a human exposure to a potentially rabid animal. Upon completion of testing, the VDHL notifies VDH Epidemiology Program staff of the result, who relays the information to the submitter and exposed individual (s).

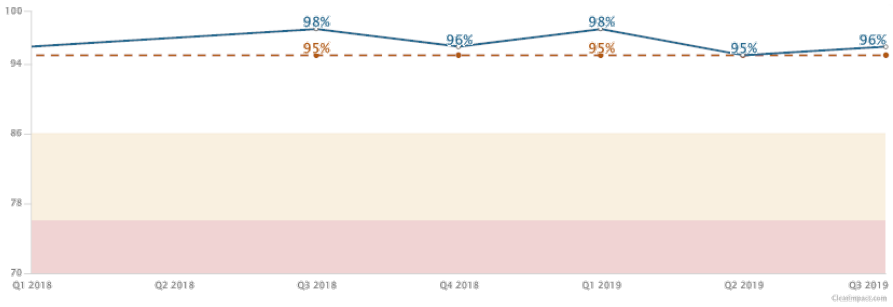
Action Plan

The VDHL implemented a rabies test module in the STARLIMS laboratory information system during the summer of 2018, which provides twice daily automatic data extracts of rabies sample and test results information to the VDH Epidemiology Program. This created efficiencies for sharing rabies test request information and providing more rapid reporting of test results. VDHL and VDH Epidemiology Program staff will plan to meet at least once/year with our critical partners such as USDA Wildlife Services and VT Fish and Wildlife to discuss sample collection, transport and submission issues.

Why Is This Important?

Rabies is a viral disease of mammals most often transmitted through the bite from a rabid animal. The rabies virus infects the central nervous system, ultimately causing disease in the brain and death. Timely rabies test results are needed to initiate the rabies post-exposure vaccination series to the exposed individuals, as well as provide the data to the medical provider that the rabies vaccination series can be stopped due to a negative test result, which also helps to relieve the anxiety of the exposed person (s) and family members.

PM GCI % of water bacteriology total Coliform/E. coli Kit A samples received on time (within 30 hour hold time)



Q3 2019	96%
Q2 2019	95%
Q1 2019	98%
Q4 2018	96%
Q3 2018	98%
Q4 2017	95%
Q3 2017	96%
Q2 2017	96%
Q1 2017	93%

Story Behind the Curve

About three out of 10 Vermont households drink water from private residential wells and it is important to test for contaminants on a regular basis. The Health Department recommends certain tests be performed to ensure that your drinking water is safe including the yearly Kit A for Total Coliform Bacterial test. Drinking water samples submitted for the Total Coliform Bacterial test must be received within 30 hours of collection to be valid for testing. The 30-hour deadline for sample receipt can be challenging for customers, especially for those customers that do not live within driving distance of the Vermont Department of Health Laboratory (VDHL). The VDHL provides written and verbal guidance to customers on the fastest means to ship the samples to meet the timeline, but some samples still do not arrive on time, resulting in the sample being rejected for testing and a free replacement kit being sent to the customer. Samples that are received beyond the 30-hour hold time impacts the customer as test results are delayed and they need to collect and re-pay for shipping or hand-deliver_a new sample for testing. The VDHL is impacted because of the time it takes to accession and reject the sample, report the results and generate/ship a replacement kit to the customer.

Partners

Partners include the Vermont Department of Health Environmental Health Division and Local Health Offices, DEC Drinking Water and Groundwater Protection Division, Home Inspectors, Town Health Officers, and the public.

What Works

The VDHL Customer Service Program provides written guidance on the fastest means to ship samples with every Kit A order and the information is also available on the VDH website. Verbal shipping guidance is also provided during face-to-face or telephone orders for Kit A water test kits. The Customer Service Supervisor communicates with the United States Postal Service when postal delivery processes change that affect sample delivery times such as the 2015 change in first class delivery time from next day to 2-5 days. The VDHL currently has a contract for state-wide courier services that is currently used for pick-up of on-demand clinical specimens, VT Forest and Parks seasonal recreational water samples at the St. Albans Local Health Office and was also used during the School Lead Pilot Project for testing of drinking water in schools.

Action Plan

In order to decrease the number of Kit A drinking water samples that are received beyond the 30-hour hold time, a pilot project for courier specimen pick-up for drinking water samples delivered by the public to a Local Health Office will be implemented. This will allow the customer to drop off a Kit A sample at a pre-determined location (Local Health Office) that will be picked up by a daily, M-F courier for delivery to the VDHL. An evaluation of the pilot project, including conformance to special specimen holding requirements such as refrigeration and establishing pick-up and delivery times will be completed. The 10 remaining (excluding the local Burlington Office) Local Health Offices will be added after the successful completion of the St. Albans office pilot project by rolling out one Local Health Office at a time to the routine courier schedule for pick-up of drinking water samples.

Why Is This Important?

A Total Coliform bacterial test is recommended every year for homeowners with private wells. Coliform bacteria are a large group of soil and intestinal bacteria that indicate potential well contamination and may cause health problems. If Total Coliform bacteria are found, the water is then checked for E. coli bacteria. Test results show whether recent animal or human waste has entered the water. Water that has tested positive for bacterial contamination should not be consumed, unless boiled for one minute. Drinking water samples submitted for the Total Coliform Bacterial test must be received with 30 hours of collection or will be rejected. Establishing a regular courier pick-up of samples at predetermined locations throughout the state will help the customer in meeting that requirement and result in less rejected samples.

Attachment 7b - Investment Scorecards (2) - SASH and HomeShare Vermont

Budget information

SASH grants:

SFY2019 SFY2018 SFY2017 SFY2016

$974,023 $974,023 $974,023 $974,023

MCO Investment expenditures for SASH: includes indirect allocations to GC MCO (per DAIL business office):

SFY2019 plan SFY2018 est. SFY2017 actual SFY2016 actual

$1,024,000 $1,023,000 $1,022,170 $1,013,283

What We Do

SASH coordinates the resources of social-service agencies, community health providers and nonprofit housing organizations to support Vermonters who choose to live independently at home. Individualized, on-site support is provided by a Wellness Nurse and a SASH Care Coordinator.

Who We Serve

SASH serves older adults as well as people with special needs who receive Medicare support. SASH touches the lives of approximately 5,000 people throughout Vermont.

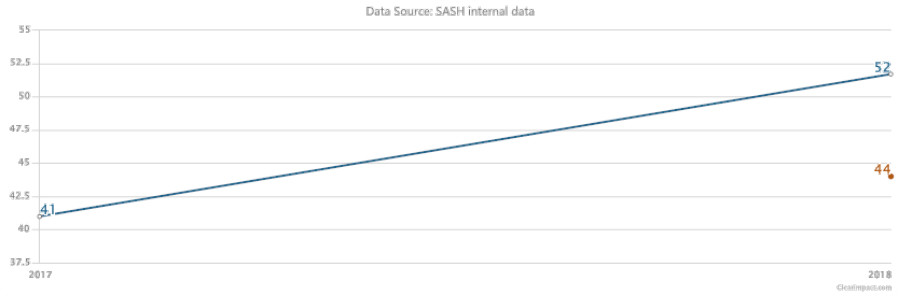
How We Impact

Benefits to SASH Participants:

- Improved quality of life
- Comprehensive health and wellness assessments
- Individualized Healthy Living Plans
- Money savings through preventive health care
- Regular check-ins by caring staff
- Health coaching and access to wellness nurses

- Help in planning for successful transitions (e.g., following hospitalization), navigating long-term care options and during a crisis
- Access to prevention and wellness programs
- Support in self-managing medications

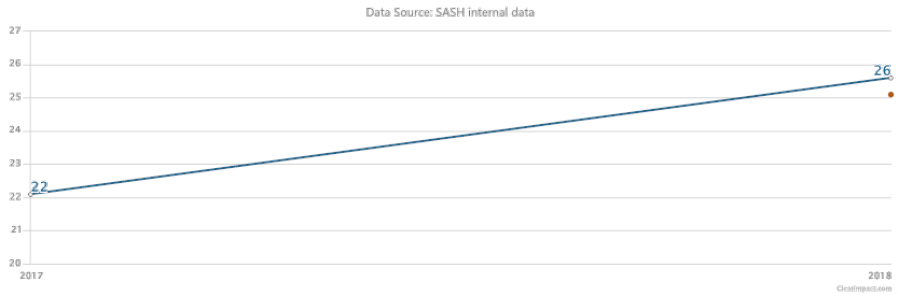
Performance Measures	Most Recent Period	Current Actual Value
PM DAIL SASH: Social Isolation	2018	52
	2017	41



Action Plan

a. Subrecipient will improve identification of SASH participants with social isolation and or loneliness and plan for interventions that will reduce the incidence of participants who score as "lonely" on UCLA Loneliness Scale. Assessment rates will increase by 3% (from May 15th 2018 report %) for all participants as of May 15, 2019.

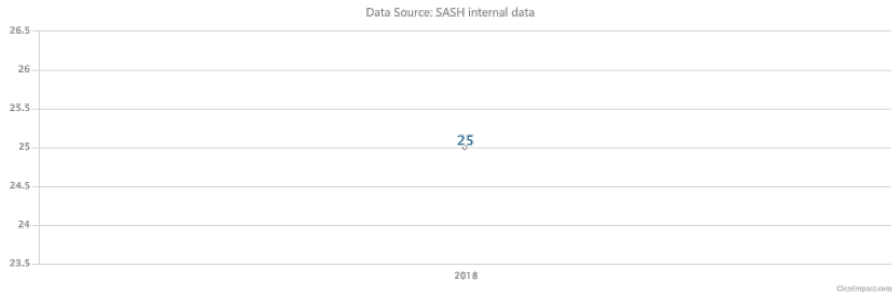
PM DAIL SASH: Suicide prevention: participant screening	2018	26
	2017	22



Action Plan

a. Subrecipient will improve the identification of participants at risk of suicide and train 25% of staff in Gatekeeper and/or UMatter training:
    i. Subrecipient will raise the rate of administering the one-question suicide screen by at least 3% (from May 15, 2018 %) by May 15, 2019.

PM DAIL SASH: Substance Use Screening 2018 25



Action Plan

a. Subrecipient will improve the identification of participants at risk of adverse substance use and systematically provide basic education materials to participants:
    i. Subrecipient will raise the rate of administering the validated pre-S-MAST-G screening question by at least 3% (from May 15, 2018 %) by May 15, 2019.

HomeShare Vermont

DAIL | Older Adults | Disabilities | GCI | homeshare

Budget information

HomeShare VT grants:

SFY2019 SFY2018 SFY2017 SFY2016

$179.940 $179,940 $179,940 $179,940

MCO Investment Expenditures for both homesharing programs: includes indirect allocations to GC MCO (per DAIL business office):

SFY2019 Plan SFY2018 est. SFY2017 actual SFY2016 actual

$342,000 $341,000 $340,882 $339,966

What We Do

HomeShare Vermont provides screening, matching and ongoing support services, pairing Vermonters who wish to live in their own homes (hosts) with others who are looking for affordable housing (guests).

Who We Serve

HomeShare Vermont serves Vermonters who are looking to share housing for mutual benefit. Most people sharing their homes (hosts) are seniors or people with disabilities, and many people looking for housing (guests) are financially challenged by market rents or are in housing transitions. Twenty percent of people served come from outside our service Counties (Chittenden, Addison, Franklin, and Grand Isle), most of whom are interested in moving into one of these Counties. As of November 1, 2019, HomeShare Vermont will expand services to include Washington, Orange and Lamoille Counties.

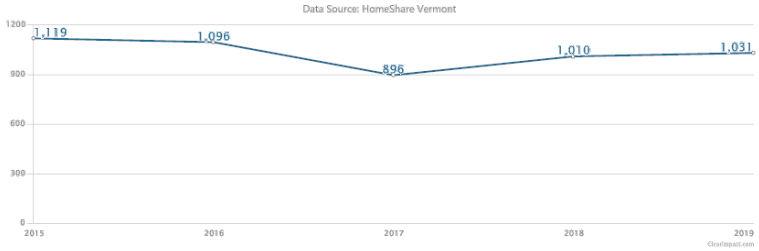
How We Impact

HomeShare Vermont:

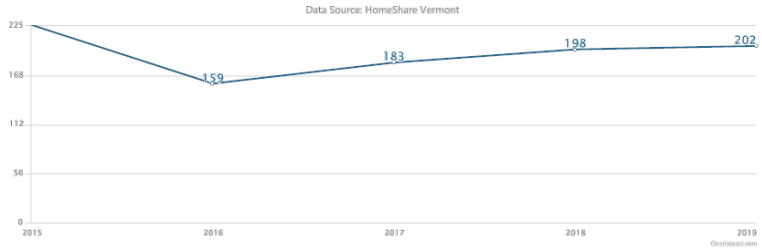
- Helps make housing more affordable for Vermonters
- Helps older Vermonters and Vermonters with disabilities live in their own homes
- Helps improve the quality of life for homesharing participants, who report that they feel safer, less lonely, eat better, and feel healthier

Performance Measures

	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM DAIL HomeShare Vermont: Total Unduplicated Number of People Served	2019	1,031	–	↗ 2	-8% ↓
	2018	1,010	–	↗ 1	-10% ↓
	2017	896	–	↘ 2	-20% ↓
	2016	1,096	–	↘ 1	-2% ↓
	2015	1,119	–	→ 0	0% →

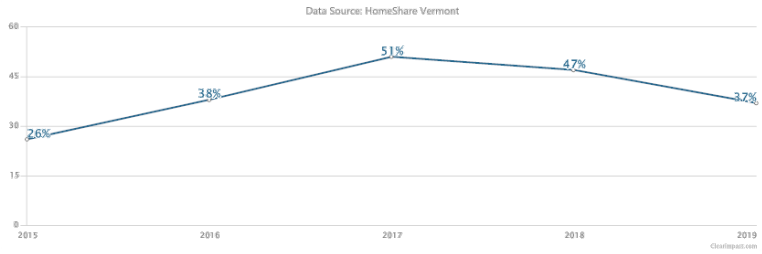


PM DAIL HomeShare Vermont: Total Unduplicated Number of People in a Match	2019	202	–	↗ 3	-11% ↓



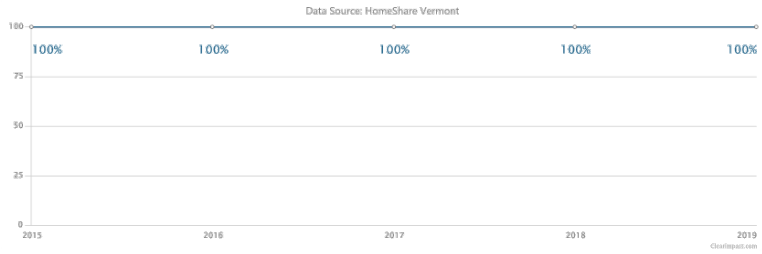
2018	198	–	↗ 2	-12% ↓
2017	183	–	↗ 1	-19% ↓
2016	159	–	↘ 1	-30% ↓
2015	226	–	→ 0	0% →

PM DAIL HomeShare Vermont: Percent of People who report they are able to stay safely at home because of a match



2019	37%	–	↘ 2	42% ↑
2018	47%	–	↘ 1	81% ↑
2017	51%	–	↗ 2	96% ↑
2016	38%	–	↗ 1	46% ↑
2015	26%	–	→ 0	0% →

PM DAIL HomeShare Vermont: Percent of People who report they have improved quality of life



2019	100%	–	→ 4	0% →
2018	100%	–	→ 3	0% →
2017	100%	–	→ 2	0% →
2016	100%	–	→ 1	0% →
2015	100%	–	→ 0	0% →

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Attachment 8 - Payment Model Scorecards (3) for Blueprint for Health - (1) Patient Centered Medical Homes, (2) Community Health Teams, (3) Womens Health Initiative

P Blueprint for Health - Patient Centered Medical Homes (PCMHs)

BP DVHA PCMH

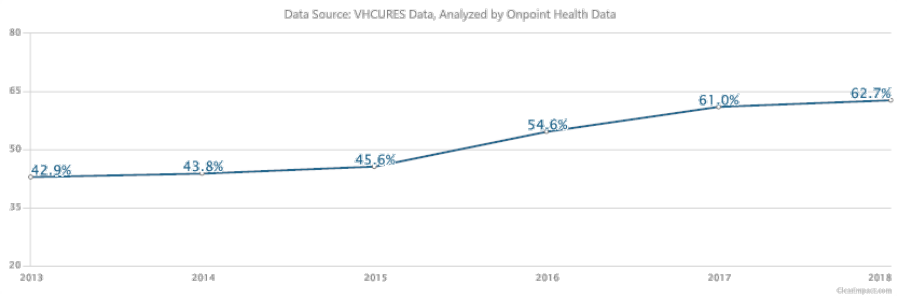
What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Patient-Centered Medical Home model utilizes a per patient per month base payment to incentivize primary care practices to be recognized as patient-centered medical homes by the National Committee for Quality Assurance (NCQA). This payment also includes performance-based payments for quality and utilization. The quality payment is determined based on the results of four measures that were selected to be representative of outcomes across the lifespan (developmental screenings that occur within the first three years of life, adolescent well-care visits, and the management of 2 chronic conditions: hypertension and diabetes).

Performance Measures

	Most Recent Period	Current Actual Value
PM PCMH Developmental Screening in the First Three Years of Life	2018	62.7%
	2017	61.0%
	2016	54.6%
	2015	45.6%
	2014	43.8%
	2013	42.9%



Notes on Methodology

This is a claim-based measure using data from VHCURES that calculates the number of children who turned 1, 2, or 3 years of age in the measurement period who were screened for the risk of developmental, behavioral, and social delays using a standardized screening tool. This is limited to those children with health coverage and attributed to a patient-centered medical home. (NQF #1448)

Partners

1. Patient Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Vermont Child Health Improvement Program
5. Early education and child care professionals

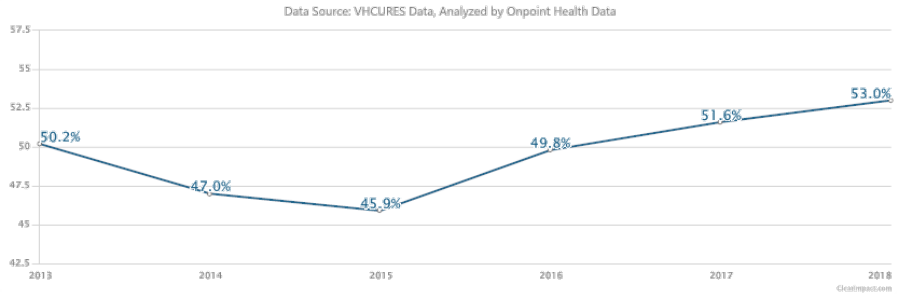
Story Behind the Curve

The Developmental Screening measure was chosen for its potential to positively impact young children at a developmentally critical time. The screenings provide opportunities for early identification and interventions that support improved development and health. Statewide organizations such as the Vermont Department of Health, the Vermont Child Health Improvement Program (VCHIP), OneCare Vermont, and the Blueprint for Health have supported efforts to use data for quality improvement initiatives and increase communication and coordination around child well-being. Currently, each pediatric-service patient-centered medical home receives their practice-level results in annual profiles provided by the Blueprint for Health.

While this payment model supports all patients in the medical home, regardless of payer, the above data show the statewide average for Medicaid members attributed to a patient-centered medical home to demonstrate how Medicaid enrollees are faring. The above data indicate that the efforts employed around the state are having a positive impact. Of note, one factor that could affect outcomes was the reinstatement of eligibility redetermination after 2016, which led to the removal of a number of individuals (often healthier and younger) from the Medicaid rolls, thereby changing the composition of the Medicaid population.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

PM PCMH Adolescent Well Care Visits



2018	53.0%
2017	51.6%
2016	49.8%
2015	45.9%
2014	47.0%
2013	50.2%

Notes on Methodology

This is a claim-based measure using data from VHCURES that calculates adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. (HEDIS measure.)

Partners

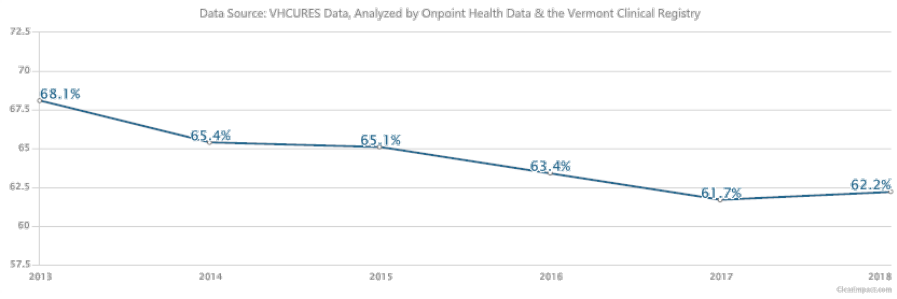
1. Patient Centered Medical Homes
2. Community Health Teams
3. Vermont Child Health Improvement Program
4. OneCare Vermont
5. School nurses

Story Behind the Curve

Adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. While this payment model supports all patients in the medical home, regardless of payer, the above data points show the statewide average for Medicaid members attributed to a patient-centered medical home to demonstrate how Medicaid enrollees are faring. The data suggest that these efforts are having an impact resulting in the most recent rate matching the national 50th percentile benchmark of 53.0%. Nevertheless, practices and communities can continue their efforts to improve further upon this measure.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods or have outcomes in the HEDIS 90th Percentile. Of note, one factor that could affect outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population.

PM PCMH Controlling High Blood Pressure



2018	62.2%
2017	61.7%
2016	63.4%
2015	65.1%
2014	65.4%
2013	68.1%

Notes on Methodology

This is a hybrid measure using claims data from VHCURES linked to clinical data from the Vermont Clinical Registry (VCR). The measure includes members age 18-85 years, who were identified in claims as having hypertension and who could be linked with a valid blood pressure reading in the VCR. Those members whose last recorded systolic blood pressure was less than 140 mm/Hg diastolic blood pressure was less than 90 mm/Hg were considered to have their hypertension in control. Of note, future measurement for this measure will adhere to the updated guidelines going forward. (NQF #0018)

Partners

1. VT Department of Health
2. OneCare Vermont
3. SASH
4. New England QIN-QIO
5. Vermont Program for Quality in Health Care

Story Behind the Curve

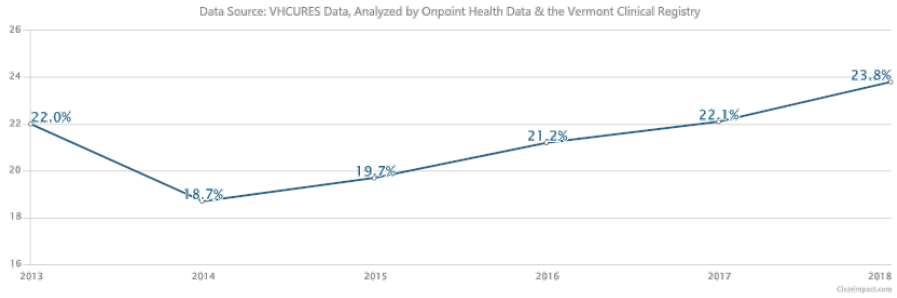
Hypertension is a risk factor for much morbidity, including heart disease and stroke, which are leading causes of death in the United States. Guideline-based medical treatment and increases in healthy behaviors can improve the management of this condition.

While these types of interventions and this payment model support all patients in the medical home, the above data points show the statewide average for Medicaid members attributed to a patient-centered medical home to demonstrate how Medicaid enrollees are faring. The above data points indicate that overall more work at the practice and communities level needs to be done to increase the proportion of those with hypertension whose blood pressure is in control. For the last three years, the proportion has persisted around 62%. Of note, one factor that could affect outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population.

Improvements seen in individual practices shows that improvements in this measure are possible and provides potential options for other practices and regions to follow. This measure requires clinical information derived from electronic medical record systems. Measure results are currently calculated using clinical data from the Vermont Clinical Registry, which is limited to those systems that can send machine readable data in standard formats through the Health Information Exchange.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions.

PM PCMH Diabetes in Poor Control **2018** **23.8%**



2017	22.1%
2016	21.2%
2015	19.7%
2014	18.7%
2013	22.0%

Notes on Methodology

This is a hybrid measure using claims data from VHCURES linked to clinical data from the Vermont Clinical Registry (VCR). The measure includes members age 18 to 75 years identified in claims as having diabetes and who could be linked with valid HbA1c measurement data in the VCR. If the HbA1c glycosylation was greater than nine percent, that member was considered “in poor control”. Increasing rates indicate that the population with diabetes needs additional interventions or is in worse health. (NQF #0059)

Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. OneCareVermont

Story Behind the Curve

Diabetes affects over 6% of the Vermont population and is a leading cause of death due to chronic conditions. Additionally, those with diabetes or pre-diabetes often go undiagnosed. However, guideline-based early detection, treatment, and self-management can help individuals with diabetes improve control of the disease and improve long-term health outcomes and quality of life.

The above data show the statewide average for Medicaid members attributed to a patient-centered medical home. Over the last three years, the proportion of people with diabetes in poor control has increased. While, one factor that could affect outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Nevertheless, efforts to improve care management should continue to change the direction of this data trend. This measure requires clinical information derived from electronic medical record systems. Measure results are currently calculated using clinical data from the Vermont Clinical Registry, which is limited to those systems that can send machine readable data in standard formats through the Health Information Exchange.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

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P Blueprint for Health - Community Health Teams (CHTs)

BP DVHA CHT

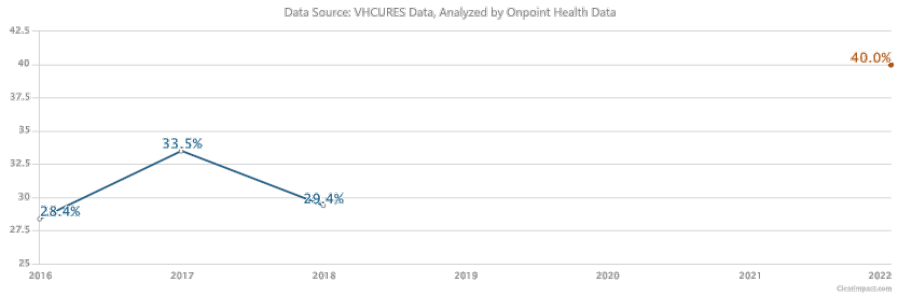
What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

Community Health Teams partner with patient-centered medical homes, hospital systems, health care and social service organizations to supplement the services available in primary care, support coordinated care, and promote prevention and wellness. A per patient per month payment is made to regional entities accountable for managing ongoing Community Health Team operations, including hiring and management of staffing, in order to meet identified community health priorities while offering services that are available for patients to access with minimal barriers (no eligibility requirements, prior authorizations, referrals or co-pays). Measures used to evaluate the overall impact of the Community Health Teams are representative of the provision of coordinated care in each region (follow-up after discharge from the emergency department for mental health or substance use disorders and patient experience of coordinated care composite).

Performance Measures

	Most Recent Period	Current Actual Value
PM CHT Follow-up After Discharge from Emergency Department Visit for Alcohol & Other Drug Dependence	2018	29.4%
	2017	33.5%
	2016	28.4%



Notes on Methodology

The red dot on the graph above represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the actual data values for Medicaid members attributed to patient-centered medical homes.

This measure shows the percent of ED visits for members, age 18 years and older, with a principal diagnosis of substance use disorder who had a follow-up visit for substance use disorder within 30 days of the ED visit. (NQF #2605)

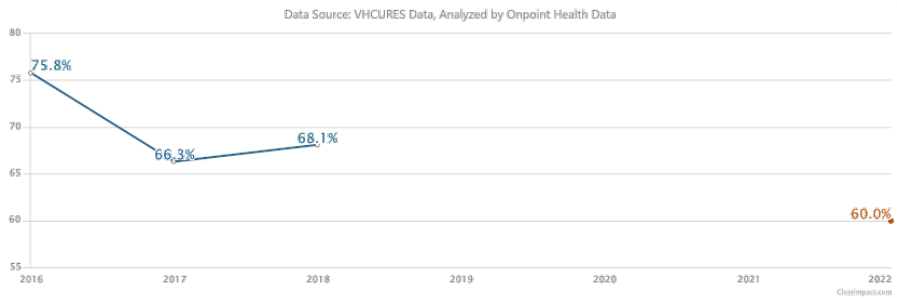
Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board
5. OneCareVermont

Story Behind the Curve

In support of people with substance use disorders, Vermont has committed to expanding access to treatment and services that can address factors contributing to these disorders, in much the same way that other chronic conditions are managed. This effort requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to substance use is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system. The population for the above data points includes Medicaid members attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. Between 2016 and 2018, the rate of follow-up among this population remains substantially below the target in the Vermont All-Payer ACO Model Agreement. While there was a slight increase from 2016 to 2018, the difference was not significant. One factor that could affect outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Community Health Teams in collaboration with practices, OneCare Vermont, and community-based services continue to work on strategies to address improving these rates.

PM CHT Follow-up After Discharge from Emergency Department for Mental Health



2018	68.1%
2017	66.3%
2016	75.8%

Notes on Methodology

The red dot on the graph above represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the State's actual values for Medicaid members attributed to patient-centered medical homes.

This measure shows the percent of ED visits for members, age 18 years and older, with a principal diagnosis of mental illness who had a follow-up visit for mental health within 30 days of the ED visit. (NQF #2605)

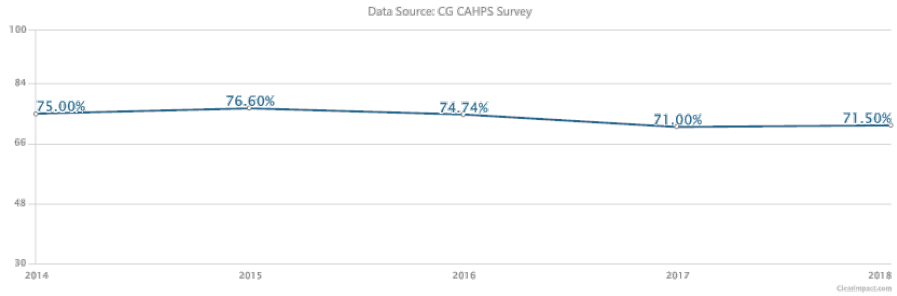
Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board
5. OneCareVermont

Story Behind the Curve

The Vermont rate of follow-up to an Emergency Department visit with a primary diagnosis of mental health condition is higher among its Blueprint-attributed Medicaid population than the All-Payer ACO Model Agreement target. However, the rate dropped between 2016 and 2017, and although it increased in 2018, it remains below the 2016 rate. One factor that could affect outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Nevertheless, the state continues to work on improving how people with mental health conditions move through the system and receive the services they need. To do so requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to mental health is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system. The above data points show the statewide average for Medicaid members attributed to patient-centered medical homes, which coordinate with community health teams. While the Community Health Team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure.

PM CHT % of Patients who Responded Yes or Always to Coordinated Care Composite, CG CAHPS Survey



2018	71.50%
2017	71.00%
2016	74.74%
2015	76.60%
2014	75.00%

Notes on Methodology

The Department of Vermont Health Access annually administers CG CAHPS survey with PCMH supplemental questions to patients of patient-centered medical homes. All practices are offered the option to participate, and typically more than 75% do. Of note, almost all primary care practices in the state are recognized as patient-centered medical homes. This measure represents responses from patients covered by all major payers, including Medicare and commercial, and is therefore not Medicaid specific.

Partners

1. Patients
2. Patient-Centered Medical Homes
3. DVHA Payment Reform Unit
4. Green Mountain Care Board
5. OneCare Vermont

Story Behind the Curve

How patients experience their care is a core element in assessing the quality of their care. As the state of Vermont works to increase integration and coordination across medical and community services, supported by Community Health Teams, to improve health outcomes and reduce unnecessary or duplicative care, the state needs to understand whether patients are seeing the results of these efforts in their own experience. Over the last few years, more than 70% of respondents reported that their primary care provider was always up-to-date on and discussed with them the care received from specialists, prescription medicines they were taking, and/or tests they had received. However, more work can be done to improve this measure. Shifting this trend involves continual improvement in person-to-person communication, practice workflows, and information technology. While the community health team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure.

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P Blueprint for Health - Women's Health Initiative

BP DVHA WHI

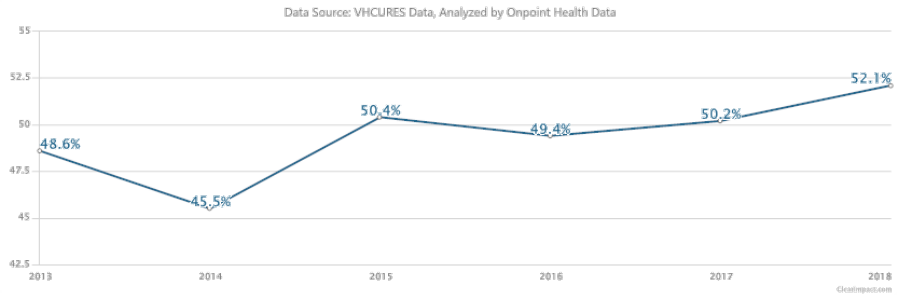
What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Women's Health Initiative includes 3 types of payments designed to incentivize Women's Health practices, and patient-centered medical homes providing women's health services, to provide high quality, integrated, and well-coordinated preventative care for women aged 15-44. Participating practices implement enhanced psychosocial screening and evidence-based interventions for depression, substance use disorder, interpersonal violence, housing instability, and food insecurity are provided by Women's Health Initiative-funded licensed mental health clinicians. Participating practices also offer comprehensive family planning services and increase access to long acting reversible contraceptives when chosen by the patient and clinically appropriate (by removing barriers that frequently prevent patients from being able to access these devices). As a result, measures that are indicative of access to care and preventative care were chosen to evaluate the overall impact of the Women's Health Initiative.

Performance Measures	Most Recent Period	Current Actual Value

PM WHI % of Chlamydia Screening in Women



2018	52.1%
2017	50.2%
2016	49.4%
2015	50.4%
2014	45.5%
2013	48.6%

Notes on Methodology

This measure shows the percentage of female members, ages 16 to 24, identified as sexually active and who had at least one test for chlamydia in the measurement year. This measure is derived from claims data.

Partners

1. DVHA Quality Unit
2. VT Department of Health
3. Planned Parenthood of Northern New England

Story Behind the Curve

The rate of chlamydia screening in Women 16-24 years old shows an overall increase, especially in recent years. In 2018 and 2019, the Blueprint for Health has worked with DVHA's Quality Unit, the Vermont Department of Health, and Planned Parenthood of Northern England to identify strategies to improve chlamydia screening rates in Women's Health Initiative participating practices.

PM WHI Adults' Access to Preventive/Ambulatory Health Services

Notes on Methodology

This measure will show the percentage of Medicaid members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

Partners

1. DVHA Quality Unit
2. VT Department of Health

3. Planned Parenthood of Northern New England

Story Behind the Curve

This measure is still in development.